

A

Accountable Care Organization (ACO): An accountable care organization (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to link provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. Often referred to as the Triple Aim: low cost, better outcomes, patient experience.

Advanced Alternative Payment Model (Advanced APM): An Advanced APM is a specific type of APM defined under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that requires participants to use certified electronic health record technology (CEHRT), provide payment for covered professional services based on quality measures comparable to those used under the Merit-Based Incentive Payment System (MIPS) and is either a Medical Home Model expanded under the CMS Innovation Center, or requires participating entities to bear more than a nominal amount of financial risk for monetary losses.

Advance Beneficiary Notice of Non-coverage (ABN): An ABN, Form CMS-R-131, is a standardized notice you or your designee must issue to a Medicare beneficiary before providing certain Medicare Part B (outpatient) or Part A (limited to hospice, home health agencies [HHAs] and Religious Nonmedical Healthcare Institutions only) items or services. You must issue the ABN when: (1) You believe Medicare may not pay for an item or service; or (2) Medicare usually covers the item or service, however Medicare may not consider the item or service medically reasonable and necessary for this patient in this particular instance.

Advanced Practice Provider (APP): Specially trained and licensed providers (other than physicians) who can provide medical care and billable services. Examples include audiologists, Certified Registered Nurse Anesthetists (CRNAs), midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, psychologists, social workers and surgeon's assistants. Formerly known as Mid-Level Providers (MLPs).

Advancing Care Information (ACI): Advancing Care Information is a performance category within the Merit-Based Incentive Payment System (MIPS). This category is based on elements of the EHR Incentive Program (Meaningful Use) and awards eligible clinicians and groups points based on their use of Certified Electronic Health Record Technology (CEHRT). For the 2017 performance year/2019 payment year, ACI counts for 25% of the MIPS score for most eligible clinicians and groups.

Affordable Care Act (ACA): Signed by President Obama on March 23, 2010, The Affordable Care Act (commonly known as the health reform law) encourages the formation of alternative payment reform. The intent of the ACA is to improve quality and lower health care costs, provide greater access to health care and provide for new consumer protections, e.g. pre-existing conditions. Some new models of care created in response to the ACA include the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs), in the belief that they will improve health care quality and slow the growth of health care spending in America. In 2015, a new provision will tie physician payments to the quality of care they provide. Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care.

Agency for Healthcare Research and Quality (AHRQ): Agency in the U.S. Department of Health and Human Services that funds research and demonstration projects relating to health care quality. Formerly the Agency for Health Care Policy and Research (AHCPR).



Alternative Payment Models (APMs): This is the acronym that is used to describe future changes to payment models based on quality and value. They include:

- Model from CMMI (Center for Medicare/Medicaid Innovation)
- MSSP (Medicare Shared Savings Plan)
- Demonstration approved under Section 1866C SSA, or
- Demonstration required by law

In practical terms this would be ACOs (Accountable Care Organizations), patient centered medical homes or bundled payments. APMs must use a certified EHR, have quality measures and bear financial risk.

Ambulatory Patient Classifications (APCs): Similar to DRGs in an inpatient setting, APCs assign ambulatory patients into case types to provide a pricing mechanism for outpatient services. These are currently undergoing the same “bundling” that DRG’s have experienced.

Ambulatory Surgery Center (ASC): A freestanding entity specifically licensed to provide surgery services that are performed on a same-day outpatient basis. To qualify for ASC certification under Medicare a facility must be: (1) a distinct entity that operates exclusively to furnish outpatient surgical services; (2) either an independent freestanding facility, or under the common ownership, licensure or control of a hospital; and (3) surveyed and approved by CMS. These are often regulated by specific state rules.

American Medical Association (AMA): The American Medical Association, founded in 1847 and incorporated in 1897, is the largest association of physicians—both MDs and DOs—and medical students in the United States.

Ancillary Services: Services other than physician and nursing services, including clinical laboratory, radiology and imaging, and other medical support services.

Appropriate Use Criteria (AUC): The underlying purpose of appropriate use criteria is to ensure that the right procedure is performed on the right patient at the right time for the right reasons, to achieve the best possible outcome. In response to the imperative for improving the utilization of cardiovascular procedures in an efficient and contemporary fashion, the American College of Cardiology Foundation (ACCF), along with imaging subspecialty societies and other organizations, developed the first set of Appropriate Use Criteria (AUC) in 2005. Approved as part of the Protecting Access to Medicare Act of 2014, referring physicians must use physician-developed appropriateness criteria when ordering advanced imaging for Medicare patients. It mandates that starting no earlier than January 1, 2018, physicians ordering advanced diagnostic imaging exams (CT, MRI, nuclear medicine and PET) must consult government-approved, evidence-based appropriate-use criteria, namely through a Clinical Decision-Support (CDS) system. Physicians furnishing advanced imaging services will only be paid if claims for reimbursement confirm that the appropriate use criteria was consulted, which CDS mechanism was used, and whether the exam ordered adhered or did not adhere to an acceptable CDS rating.

B

Bad Debt: Accounts receivable that are declared to be uncollectible and are usually written off. A medical practice may choose to outsource the collection of these accounts to a collection agency.

Balanced Budget Act of 1997 (BBA): The Act (Public Law 105-33) that contained 335 provisions related to the Medicare program that required the development of new regulations and policies for providers. Most notably, this legislation reduced Medicare provider payments and restructured the formula used to set Medicare reimbursement rates.

Benchmarking: The process of comparing performance to a pre-established standard or performance of another facility or group with the goal of determining best practices and achieving superior performance.

Bonus Pool: An amount of money set aside to be given to providers for meeting certain performance standards. Including but not limited to quality, service, strategic and experience (providers may be rated by both patients and referring physicians). They can NOT include incentives for referrals or reduction in Medicare beneficiaries' access to care.

Bundled Payments for Care Improvement (BPCI): BPCI is an example of a bundled payment initiative and is defined as the reimbursement of health care providers (such as hospitals and physicians) “on the basis of expected costs for clinically-defined episodes of care.” It is also known as episode-based payment, episode payment, episode-of-care payment, case rate, evidence-based case rate, global bundled payment, global payment, package pricing or packaged pricing.

Bundling CPT Codes: “Bundling” occurs when a procedure or service with a unique CPT or HCPCS code is included as part of a “more extensive” procedure or service provided at the same time. No additional payment is available. EP and cath procedures have been bundled in the DRG world and are now bundled in an outpatient world.

Business Associate (BA): Under HIPAA, this is a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right.

C

Capital Expenditure: Expenses that will be deducted over a number of years representing the asset's useful life as the purchase price is depreciated over the years. Capital expenditures are defined by the Internal Revenue Service but typically include: office buildings, building improvements, major medical or office equipment, information technology, and office furniture. Lease hold improvements are often capitalized over 29 years.

Capitation: Capitation refers to a form of a healthcare payment system. In a capitation model, a health care provider or individual hospital is paid by the insurer (or other payer) a fixed amount per patient during a given period of time.

Cardiac Bundled Payment Models: In December 2016, the Centers for Medicare and Medicaid Services (CMS) finalized episode payment models for acute myocardial infarction (AMI Model), coronary artery bypass graft (CABG model), and cardiac rehabilitation (CR Incentive Payment Model). These models are scheduled to begin on July 1, 2017 in selected metropolitan statistical areas (MSAs) and run through December 31, 2021. The AMI and CABG models will hold a hospital financially accountable for an episode of care running 90 days after discharge to incentivize care coordination. The CR Incentive Payment Model will provide additional retrospective payments to participating hospitals to increase the utilization of cardiac rehabilitation services.

Cardiovascular Service Line Co-Management (CVSL): This is a contractual management services agreement between a hospital or health system and a group of cardiovascular physicians (and perhaps other specialists) to share responsibility for the outcomes of hospital-based cardiovascular service line.

Carve-Out: Services separately designed and contracted to an exclusive, independent provider by a managed care plan. For example, psychiatry is often a carved-out service.



Case Management: Patients with a specific diagnosis or who require extensive services are identified and a plan is developed to systematically coordinate patient care to insure appropriate care with the best outcome and to reduce the costs of providing service.

Case Mix: Set of categories of patients (type and volume) treated by a healthcare organization and representing the complexity of the organization's case load. A CMI - case mix index is attributed to every hospital as well as every DRG.

Case Rate: The rate for an established medical procedure or diagnosis including all services and charges that relate to that procedure or diagnosis. It is best used for procedures or diagnoses with quantifiable services and a specific length of service. An example would be transplants.

Centers for Medicare and Medicaid Services (CMS): The agency, part of the U.S. Department of Health and Human Services, which manages the Medicare and Medicaid programs and oversees the State Children's Health Insurance Program (SCHIP) with the Health Resources and Services Administration. Formerly the Health Care Financing Administration.

Center for Medicare and Medicaid Innovation (CMMI): The Center for Medicare and Medicaid Innovation, also known as the Innovation Center, was created under the Patient Protection and Affordable Care Act. CMMI was created to test payment and delivery system models that have the potential to maintain or improve the quality of care in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while slowing rising costs.

Certified Coding Specialist (CCS): Certification awarded by the American Health Information Management Association (AHIMA) to individuals who have demonstrated competence in coding hospital inpatient and outpatient services.

Certified Coding Specialist - Physician-based (CCS-P): Certification awarded by the American Health Information Management Association (AHIMA) to individuals who have demonstrated competence in coding physician services.

Certified EHR Technology (CEHRT): To get an incentive payment, you must use an electronic health record (EHR) that is certified specifically for the EHR Incentive Programs, under ONC guidelines. Certified EHR technology gives assurance to purchasers and other users that an EHR system or module offers the necessary technological capability, functionality and security to help them meet the meaningful use criteria. Certification also helps providers and patients be confident that the electronic health IT products and systems they use are secure, can maintain data confidentially and can work with other systems to share information.

Certified Professional Coder (CPC): Certification awarded by the American Academy of Professional Coders (AAPC) to individuals who have demonstrated competence in ICD-9-CM diagnosis coding and HCPCS/CPT procedure coding.

Certified Professional Coder – Hospital (CPC-H): Certification awarded by the American Academy of Professional Coders (AAPC) to individuals who have demonstrated competence in coding hospital outpatient services.

Certified Professional Coder – Payer (CPC-P): Certification awarded by the American Academy of Professional Coders (AAPC) to individuals who have demonstrated competence in the application of ICD-9-CM diagnosis coding and HCPCS/CPT as it pertains to the adjudication of provider claims.

Charge Description Master (CDM): The charge description master (also called the charge master) is a master price list of supplies, devices, medications, services, procedures and other items for which a distinct charge to the patient exists. Typical data elements found in the CDM include: charge description, CPT or HCPCS code, revenue code, charge amount, department code, charge code, etc. Therefore, the responsibility for maintaining the database may fall to several individual departments (e.g., laboratory radiology). In addition, some organizations choose to have a central CDM position that interacts with the various departments to ensure that accurate data are maintained in the CDM and address any issues that may arise.

Chronic Care Management (CCM): Chronic Care Management is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions. In addition to office visits and other face-to-face encounters (billed separately), these services include communication with the patient and other treating health professionals for care coordination (both electronically and by phone), medication management, and being accessible 24 hours a day to patients and any care providers (physicians or other clinical staff). The creation and revision of electronic care plans is also a key component of CCM. Only one provider can bill for this service.

Clinical Decision Support Software (CDS): Designed to make relevant information accessible to decision makers based on AUC criteria and will be mandatory for all Advanced Imaging (nuclear, CT, PET and MRI) for Medicare patients in 2017.

Clinical Documentation Improvement (CDI): CDI is a process or program typically used in hospitals that employs specialists who review clinical documents, providing feedback and education to physicians. The feedback is designed to fill gaps in documentation such as questions about coding, quality measures and overall care management of a patient. This kind of feedback loop to the physician is intended essentially to make sure that documentation is high quality and corresponds to care delivered as well as the diagnoses that are being made.

Clinical Integration: A system designed to improve collaboration among different health care providers and sites to ensure higher quality, better coordinated and more efficient services for patients. Often carries a financial gain to providers based on generic medication ordering and other guidelines; it is currently used in the private payer world.

Clinical Laboratory Improvement Amendments (CLIA): A CMS regulated entity that regulates ALL laboratory testing (except research). There are waived and non-waived testing.

Clinical Quality Measures (CQM's): These tools help measure and track the quality of health care. They measure many aspects of patient care including: health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagements, population and public health, and adherence to clinical guidelines. Do not confuse these with the PQRS measures.

CMS Web Interface: The CMS Web Interface, also known as the GPRO Web Interface, is a secure internet-based application made available by CMS for reporting Physician Quality Reporting Program (PQRS) or Merit-Based Incentive Payment System (MIPS) group level quality data. Many Medicare Accountable Care Organization (ACO) participants also report quality data through the CMS Web Interface. Registration with CMS is required in order to report via the CMS Web Interface.

Community Health Information Network (CHIN): Information network linking providers, insurers, patients and suppliers throughout a community.



Complications and Comorbidities (CCs): For the purposes of coding diagnoses on claims, a complication is a condition that exists during a hospital stay. A comorbidity is a pre-existing condition that affects the treatment received and/or prolongs the length of stay. In some cases, DRG payment may change due to patient complications and comorbidities. Complications and comorbidities should be documented in the patient record and listed on the discharge face sheet.

Comprehensive Error Rate Testing (CERT): An annual process whereby CMS evaluates a random sample of claims to see if they were paid accurately. To be educational in nature, but as we have seen, it often results in other audit activities.

Comprehensive Primary Care Initiative (CPC/CPCI): The Comprehensive Primary Care (CPC) initiative is a four-year multi-payer initiative designed to strengthen primary care. Since CPC's launch in October 2012, CMS has collaborated with commercial and state health insurance plans in seven U.S. regions to offer population-based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five "Comprehensive" primary care functions. These five functions are: (1) Risk-stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; and (5) Coordination of Care across the Medical Neighborhood.

Computer Assisted Coding System (CAC/CACS): A computer assisted coding system (CACS) is a computer software application that analyzes health care documents and produces appropriate medical codes for specific phrases and terms within the document. Similar conceptually to "spell check," the software uses natural language processing (NLP) in order to highlight key terms and phrases for ICD-9 CM, ICD-10 CM and CPT coding. In addition, CACSs analyze the context to determine whether or not a particular instance requires coding. For example, the software can determine that the term "cancer" requires coding when it's a diagnosis, but not when it is referring to a "family history of cancer."

Computerized Provider Order Entry (CPOE) A computerized system typically deployed in hospitals or any practice undergoing MU (Meaningful Use) wherein the provider directly enters orders for distribution to various operational systems or departments for their action. CPOE systems are most effective when coupled with clinical decision support to ensure complete, accurate and legible orders.

Consumer Assessment of Health Plans Survey (CAHPS®): A Medicare beneficiary satisfaction survey required by CMS. H-CAHPS is for hospitals and CAHPS for PQRS/CAHPS for MIPS (formerly known as CG-CAHPS) is for physician groups (clinical groups).

Conversion Factor: A component of the Resource Based Relative Value Scale which sets reimbursement rates for services paid for by Medicare.

Cost (Resource Use): Cost, also known as Resource Use, is a performance category within the Merit-Based Incentive Payment System (MIPS). Cost measures eligible clinicians and groups on the resources used to treat attributed Medicare beneficiaries based on Medicare claims data and measures. Unlike the other MIPS categories, Cost requires no reporting by eligible clinicians and groups. For the 2017 performance year/2019 payment year, Cost will not be factored into the MIPS score, but will be included in future years.

Current Procedural Terminology (CPT): The Current Procedural Terminology (CPT) code set is a medical code set maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set (copyright protected by the AMA) describes medical, surgical and diagnostic services; and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients,

accreditation organizations, and payers for administrative, financial and analytical purposes. New editions are released each October.

D

Data Mining: The process used to query and analyze a data warehouse for trends.

Data Warehouse (DW/EDW): Also known as an enterprise data warehouse (EDW), a data warehouse is a system used for reporting and data analysis. DWs are central repositories of integrated data from separate databases or silos of information within a health care system, allowing the MIS system to handle all the data from several sources as if from one source.

Days per Thousand: Utilization measure of hospital days incurred annually for each thousand covered lives per year.

Decision Support Software: Designed to make relevant information accessible to decision makers.

Department of Health and Human Services (HHS): Manages the Medicare and Medicaid programs and oversees the State Children's Health Insurance Program (SCHIP) with the Health Resources and Services Administration.

Department of Justice (DOJ): Collaborates with other Medicare agencies including OIG (Office of Inspector General) and HHS to provide a nationwide strategy to prevent fraud.

Designated Health Services: The services (determined by the Stark Law) that a physician cannot refer a Medicare or Medicaid patient to if the physician has an ownership or investment interest in the facility providing the service. The services include medical laboratory, physical therapy, radiology and imaging, occupational therapy, radiation therapy, DME, prosthetics and orthotics, home health, outpatient prescription drugs, and inpatient and outpatient hospital services.

Diagnosis Related Groups (DRGs): Classification system developed at Yale University using 383 major diagnostic categories based on the ICD-9 codes. This procedure assigns patients into case types. DRGs were originally designed to facilitate the utilization review process but they are also used to analyze patient case mix in hospitals and determine hospital reimbursement policy. See also MS-DRG.

Digital Imaging and Communications in Medicine (DICOM): Standard protocol for exchanging medical images among computer systems.

Disease Management: The integrated monitoring of a patient, particularly with a chronic illness, to focus on prevention of recurrence, improved quality of life and cost-effective care. Also refers to the systematic study of a diagnosis or intervention to focus on the outcomes for a population, rather than an individual patient.

E

Economic Credentialing: The selection process of using economic criteria (number of referrals, number of tests, etc.) in addition to quality of care and professional competency to determine a provider's qualifications to be added to hospital medical staff or to continue to have staff privileges.



Electronic Clinical Quality Measures (eCQM's): Finalized as part of Stage 2 in MU - these quality measures must be reported electronically. You often attest to their submission BUT you must retain proof of the measures and their requirements.

Electronic Data Interchange (EDI): Exchange of information between two or more organizations using electronic transmission. EDI uses network transaction standards from the ANSI Accredited Standards Committee (ASC) X12.

Electronic Health Record (EHR): A computer-based medical record system that provides for the capture of data from multiple sources and is used as the primary source of information to support clinical decision making at the point of care.

Electronic Medical Record (EMR): A term that is often used in physician practices to refer to EHRs.

Electronic Prescribing (eRX): A prescriber's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care.

Electronic Remit Advice and Standard Paper Remit (ERA/SPR/RA): After Medicare processes a claim, either an ERA or an SPR is sent with final claim adjudication and payment information. One ERA or SPR usually includes adjudication decisions about multiple claims. Itemized information is reported within that ERA or SPR for each claim and/or line to enable the provider to associate the adjudication decisions with those claims/lines as submitted by the provider. The ERA or SPR reports the reason for each adjustment, and the value of each adjustment. Adjustments can happen at line, claim or provider level. In case of ERA, the adjustment reasons are reported through standard codes.

Electrophysiology (EP): Cardiac electrophysiology is the science of elucidating, diagnosing and treating the electrical activities of the heart. It is now a recognized sub-specialty with its own code in PECOS.

Eligible Professional (EP)/Eligible Clinician (EC): Healthcare professionals and hospitals must meet the eligibility criteria defined by law in order to participate in and receive incentive payments for the Medicare quality reporting programs (PQRS, Value-Based Payment Modifier, EHR Incentive, Merit-Based Incentive Payment System [MIPS]). The definition for an EP/EC may vary by program. Under MIPS, CMS is beginning to use the term Eligible Clinician in place of Eligible Professional.

Episode of Care: All the care and services provided for a specific diagnosis for a specific time frame.

Evaluation and Management Coding (E/M): E/M services refer to visits and consultations furnished by physicians and other health care providers. CPT® codes for services where physicians spend face-to-face time with a patient. The key elements involved in an E&M service are (1) obtaining a medical history, (2) performing a physical examination and (3) making medical decisions. The medical decisions may involve varying levels of medical involvement ranging from low to high. Codes used for E&M services delineate this involvement into five levels.

Evergreen Contracts: Refers to managed care contracts that renew automatically after the initial term has been completed.

Evidence-Based Medicine: The practice of medicine based on clinical decision support using evidence of best practices rather than an arbitrary set of rules.



Exempt Employees: Employees exempt from the minimum wage and overtime requirements of the Fair Labor Standards Act, provided they meet certain tests regarding job duties and responsibilities and are compensated on a salary basis at not less than stated amounts. Strictly regulated and state and federal rules must be followed.

F

False Claims Act (FCA): This statute prohibits the presenting of a claim to the United States that the claimant knows to be “false, fictitious, or fraudulent,” including billing for services that weren’t rendered or weren’t medically necessary and filing claims at inflated rates. Ignorance of the law is not an excuse. Over-coding is often cited as submitting false claims as is performing “unnecessary” procedures.

Family and Medical Leave Act of 1993 (FMLA): The act allowing employees up to 12 weeks of unpaid leave within a 12-month period for a serious health condition, the birth or adoption of a child, or caring for a relative with a serious illness. Employees are eligible if they have worked for the company or practice for more than one year, for 1,250 hours over the previous 12 months, and if there are at least 50 employees within the organization.

Fee-for-Service (FFS): The patient or payer is charged according to a fee schedule set for each service and/or procedure to be provided and the patient’s total bill will vary by the number of services/procedures actually provided.

Fee-for-Value (FFV): Payments based on the value of care provided rather than the traditional model of healthcare where providers are paid by the number of visits and services provided (fee-for-service).

Fee Schedule (FS): A list of CPT codes and dollar amounts an insurance company will pay for a particular medical service. See also MPFS.

Fee Schedule Updates (FS/PFS/IPPS/HOPPS): There are several fee schedules that are released annually. They all have a 90-day comment period before they are finalized. PFS - physician fee schedule is proposed in July and the final released by 11/1 with an effective date of 1/1 annually; the IPPS is the Inpatient fee schedule and is effective 10/1 annually, HOPPS - hospital outpatient fee schedule is released the same schedule as the PFS.

Foundation: May be created by a hospital or delivery system as a nonprofit corporation to provide medical services. May be used to acquire the assets of a medical group for a fair market price and then contract for physician services. The foundation typically has the management responsibility and employs the non-physician staff.

Fraud and Abuse: A broad term covering a variety of illegal and unethical practices, usually applied to improper billing processes, making false claims and receiving kickbacks. Several federal laws exist related to fraud and abuse for Medicare services, including the False Claims Act, Medicare and Medicaid Patient Protection Act of 1987, and the Anti Kickback Statute.

Full-Time Equivalent (FTE): An employee or physician who regularly works the number of hours the practice considers to be the minimum number of hours for a normal work week. This could be 36, 40 or 50 hours or some other standard.

G

Gainsharing: A compensation plan that relates compensation to organizational goals and objectives, including reducing overhead, reducing LOS (length of stay) increasing revenue or improving patient satisfaction. Often used to describe a contractual arrangement involving a hospital and a group of physicians directed at the promotion of hospital cost savings. See also Profit Sharing and Clinical Service Line Co-Management. This needs federal approval before it can be undertaken.

Geographic Practice Cost Index (GPCI): A component of the Resource Based Relative Value Scale which sets reimbursement rates for services paid for by Medicare. The GPCI adjusts inputs reflecting the cost differences of delivering medical services between regions in the physician fee schedule. The Medicare Physician Fee Schedule defines the GPCI for each year.

Group Practice Reporting Option (GPRO): In accordance with section 1848(m)(3)(C) of the Social Security Act (the Act), CMS created a new group practice reporting option (GPRO) for the Physician Quality Reporting System (PQRS) in 2010. Group practices participating in GPRO that satisfactorily report data on PQRS measures for a particular reporting period are eligible to earn a PQRS incentive payment equal to a specified percentage of the group practice's total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during the reporting period. To earn an incentive for the 2015 PQRS program year, group practices participating in GPRO may register to participate in GPRO via: (1) Qualified PQRS registry; (2) Web interface (for groups of 25+ only); (3) Direct electronic health record (EHR) using certified EHR technology (CEHRT); (4) CERHT via Data Submission Vendor; (5) CAHPS via CMS-certified survey vendor (for groups of 25+ only). You MUST self-nominate and chose a reporting mechanism that can NOT be changed after September of the reporting year.

The Merit-Based Incentive Payment System (MIPS) also allows group practice reporting. Self-nomination is only required for group practices wishing to report quality data via the CMS Web Interface or the CAHPS for MIPS survey.

Group Purchasing Organization (GPO): An organization that unites healthcare providers in order to contract for the purchase of equipment, supplies and services at discounted prices based on high volume. The members must often agree to make a minimum amount of purchases through the GPO.

H

Health Care Clearinghouse: A public or private entity that does either of the following: (1) Processes information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (2) Receives a standard transaction from another entity and processes information into nonstandard format or nonstandard data content for a receiving entity. Entities may include, but aren't limited to, billing services, repricing companies, community health management information systems or community health information systems, and "value-added" networks and switches.

Healthcare Common Procedure Coding System (HCPCS): Identifiers in a standardized coding system that are used primarily to identify products, supplies and services not included in the Current Procedural Terminology (CPT®). The development and use of the HCPCS began in the 1980's and the codes are maintained jointly by the America's Health Insurance Plans, the Blue Cross and Blue Shield Association and the Centers for Medicare

& Medicaid Services.

Health Care Fraud Prevention and Enforcement Action Team (HEAT): A partnership between DOJ (Department of Justice), HHS (Health and Human Service), and other agencies to form strike forces to combat fraud.

Healthcare Integrity and Protection Data Bank (HIPDB): This web site is integrated with the National Practitioner Database and is available to federal and state government agencies to combat fraud and abuse in health insurance and health care delivery. The HIPDB is primarily a flagging system that serves to alert users that a comprehensive review of a practitioner's, provider's or supplier's past actions may be prudent. Access to the site is limited.

Health Care Quality Improvement Act (HCQIA): This federal act, passed in 1996, provides liability protection for physicians and hospitals that participate in peer review; it established a national clearinghouse to collect physician disciplinary and malpractice information.

Health Information Exchanges (HIE): The mobilization of healthcare information electronically across organizations within a region, community or hospital system.

Health Information Technology (HIT): The concept of using electronic devices and media in all forms in health care to achieve quality, cost efficiency and effectiveness benefits.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Law passed by Congress to provide continuous insurance coverage and reduce insurance fraud and abuse. The Administrative Simplification section requires adoption of standards for claims and other financial and administrative transactions, code sets, identifiers, privacy and security.

Health Level Seven (HL7): An ANSI-accredited group that defines standards for the cross-platform exchange of information within a healthcare organization.

Health Professional Shortage Area (HPSA): Federal designation for areas with shortages of health care providers. Facilities located in a HPSA receive a 10 percent bonus payment for Medicare services. This bonus is based on the amount actually paid (80 percent of the fee schedule rate) and not the Medicare allowed amount.

High Priority Measure: A High Priority Measure is a Merit-Based Incentive Payment System (MIPS) quality measure that falls under one of the following domains: outcome, appropriate use, patient safety, efficiency, patient experience, care coordination. Under the MIPS Quality performance category, bonus points will be awarded to eligible clinicians and groups that report High Priority Measures.

Hospital-Acquired Conditions (HAC): The Affordable Care Act (ACA) established the Hospital-Acquired Conditions (HAC) Reduction Program to encourage hospitals to reduce HACs. HACs are a group of reasonably preventable conditions that patients did not have upon admission to a hospital, but which developed during the hospital stay. It has two components: 1) A composite patient-safety measure; and 2) consists of two hospital-acquired infection measures. Additional infection measures will be added in years 2016 and 2017. Effective beginning FY 2015, the law requires the Secretary of the Department of Health and Human Services to reduce payments to hospitals that rank in the quartile of hospitals with the highest Total HAC Scores by 1 percent.

Hospital Outpatient Prospective Payment System (HOPPS): On August 1, 2000, the Centers for Medicare & Medicaid Services (CMS) began using the OPSS, which was authorized by Section 1833(t) of the Social Security Act (the Act) as amended by Section 4533 of the Balanced Budget Act of 1997. OPSS pays for designated hospital outpatient services, including certain Medicare Part B services furnished to hospital inpatients when Part A payment cannot be made.

I

Improvement Activities (Clinical Practice Improvement Activities): Improvement Activities, also known as Clinical Practice Improvement Activities, is a performance category within the Merit-Based Incentive Payment System (MIPS). This category is a new element of Medicare quality reporting introduced under the Medicare and CHIP Reauthorization Act of 2015 (MACRA). Eligible clinicians and groups are awarded points based on their participation in a menu of activities that contribute to improved patient care. For the 2017 performance year/2019 payment year, the Improvement Activities category counts toward 15% of the MIPS score for most eligible clinicians and groups.

In Office Ancillary Services Exception: The Stark law generally prohibits physicians from making designated health service referrals to organizations with which those physicians (or an immediate family member) have a financial relationship, unless the service is delivered through their own medical practice. The Stark law can be very complex, ensure you understand all rules and exceptions that may apply. (E.g. There are very specific rules that must be followed for any office location that is not functional on a full-time basis.)

Independent Practice Association (IPA): An association or network of licensed providers and/or medical practices. An IPA is usually a unique legal entity, most often operating on a for-profit basis. Typically, the primary purpose of the IPA is to secure and maintain contractual relationships between providers and health plans.

Inpatient Prospective Payment System (IPPS): Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

International Classification of Diseases, Ninth Revision (ICD-9): Medical practices currently use the International Statistical Classification of Diseases and Related Health Problems, Ninth Edition Clinical Modification (ICD-9-CM), volumes 1, 2 and 3 for diagnosis and inpatient procedure classification. The ICD-9-CM was developed in the 1970s and is owned and administered by the World Health Organization.

International Classification of Diseases, Tenth Revision (ICD-10): ICD-10 is a diagnostic coding system implemented by the World Health Organization (WHO) in 1993 to replace ICD-9, which was developed by WHO in the 1970s. ICD-10 is in almost every country in the world, except the United States. When we hear “ICD-10” in the United States, it usually refers to the U.S. clinical modification of ICD-10: ICD-10-CM. This code set is scheduled to replace ICD-9-CM, our current U.S. diagnostic code set, on Oct. 1, 2015. Another designation, ICD-10-PCS, for “procedural coding system,” was adopted in the United States. ICD-10-PCS replaced Volume 3 of ICD-9-CM as the inpatient procedural coding system. CPT® will remain the coding system for physician services.

L

Local Coverage Determination (LCD): Local coverage determination means a determination by a fiscal intermediary or a carrier (Medicare) under part A or part B, as applicable, respecting whether or not a particular item or service is covered. Every carrier has their own set of LCD's and are unique to Medicare Part A and Part B. Examples of local Medicare carriers include: First Coast Service Options (FSCO), Wisconsin Physicians Service Insurance (WPS), Noridian, Palmetto GBA, National Government Services (NGS), etc.

Low-Volume Threshold: Certain clinicians and groups may be exempt from the Merit-Based Incentive Payment System (MIPS) if they meet the Low-Volume Threshold. For the 2017 performance year/2019 payment year, the Low-Volume Threshold is defined as clinicians or groups that have \$30,000 or less in Medicare Part B allowed charges and see 100 or fewer Medicare beneficiaries in a year.

M

Major Complications and Comorbidities (MCCs): For the purposes of coding diagnoses on claims, a major complication is typically an acute condition that exists or arises during a hospital stay that may prolong the length of stay and generally require a substantial increase in hospital resources. Hospital stays that have documented major complications and comorbidities are assigned the highest paying DRG assignment. At times hospital acquired conditions can NOT be coded to the higher DRG payment.

Management Information System (MIS): Broadly refers to a computer-based system that provides managers with the tools to organize, evaluate and efficiently manage departments within a health care organization. In order to provide past, present and prediction information, a management information system can include software that helps in decision making, data resources such as databases, the hardware resources of a system, decision support systems, people management and project management applications, and any computerized processes that enable the department to run efficiently.

Management Services Organization (MSO): An entity organized to provide various forms of practice management and administrative support services to health care providers. These services may include centralized billing and collections services, management information services and other components of the managed care infrastructure. MSOs do not actually deliver health care services. They may be jointly or solely owned and sponsored by physicians, hospitals or other parties or they may expand their ownership base by involving outside investors. Some MSOs also purchase assets of affiliated physicians and enter into long-term management service arrangements.

Master Patient Index (MPI): A file of basic demographic data about the patients in a health care organization or the persons enrolled in a health plan and the identifiers assigned to those patients or persons to link them with their health records. An enterprise-wide master patient index (EMPI) integrates all master person indexes in an enterprise so as to achieve a common index in order to identify and link all the records for a given patient.

Meaningful Use (MU): A set of standards defined by the Centers for Medicare & Medicaid Services (CMS) Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria. The objective of the Meaningful Use program, by using a certified electronic health record (EHR), is to improve quality, safety, efficiency and reduce health disparities; engage patients and family; improve care coordination, and population and public health; and maintain privacy and security of patient health information. The program objectives will evolve in three stages over a period of 5

years. Stage 1: 2011-2012 Data capture and sharing; Stage 2: 2014 Advance clinical processes; Stage 3: 2016 Improved outcomes.

Measure Applicability Validation (MAC): MAV is a process applied as part of the PQRS Program to individual eligible professionals (EPs) or group practices that report less than nine measures, or nine or more measures with less than three NQS domains to determine if there were related measures that may have been reported. MAV is triggered in situations where the individual EP or groups practice reports any combination of measures and domains with less than nine measures across three domains. The only way to avoid triggering the MAV process is to report at least nine measures across three domains. If the total of all the measures chosen to report does not equal at least nine measures AND at least three domains the MAV process is initiated.

Medical Cost (Loss) Ratio (MCR/MLR): A comparison of a health insurance company's healthcare costs to its premium revenues. MLR requires insurance companies to spend at least 80%-85% of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases. If insurance companies fail to meet this standard, they will be required to provide a rebate to their customers starting in 2012. Also known as Medical Care Ratio, Medical Loss Ratio and Medical Benefit Ratio.

Medical Economic Index (MEI): Developed in 1975, the MEI is a measure of practice cost inflation as a way to estimate annual changes in physician operation costs and earning levels. It is used as part of the SGR pricing process.

Medicare Access and CHIP Reauthorization Act (MACRA): MACRA was signed into law on April 16, 2015 as the fix for the Sustainable Growth Rate (SGR). It's the first real step in moving away from fee-for-service reimbursement and towards value reimbursement. With MACRA, we will see significant changes to Part B physician reimbursement over the next several years. Some of those changes include:

- Permanent repeal of the SGR
- Annual reimbursement updates of 0.5 percent for 2015 - 2019; the 2020 rate is to be constant through 2025
- Introduced Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Models (APM)
- Value-Based Modifier Program (VBM) along with PQRS and Meaningful Use will sunset on December 31, 2018

Medicare Administrative Contractors (MAC): CMS relies on a network of MACs to process Medicare claims; MACs serve as the primary operational contact between the Medicare Fee-For-Service program, and approximately 1.5 million health care providers enrolled in the program. Often criticized, each MAC can and does interpret Medicare policy their own way. MACs enroll health care providers in the Medicare program and educate providers on Medicare billing requirements, in addition to answering provider and beneficiary inquiries. Collectively, the MACs and the other Medicare claims administration contractors process nearly 4.9 million Medicare claims each business day, and disburse more than \$365 billion annually in program payments.

Medicare Integrity Program (MIP): The Health Insurance Portability and Accountability Act (also known as the Kassebaum-Kennedy legislation) includes a provision establishing the "Medicare Integrity Program." That provision gives the Centers for Medicare and Medicaid Services (CMS) specific contracting authority, consistent with Federal Acquisition Regulations, to enter into contracts with entities to promote the integrity of the Medicare program. This program allowed CMS to hire contractors to review providers and assist states in their efforts to eliminate fraud.

Medicare Learning Network (MLN): The Centers for Medicare & Medicaid Services (CMS) developed MLN Matters® articles to ensure the health care professional community has immediate access to the latest changes to CMS Programs, Medicare coverage, billing and payment rules in a brief, accurate, and easy-to-understand format. The national articles are prepared in consultation with clinicians, billing experts, and CMS subject matter experts. They are tailored, by content and language, to specific provider type(s) who are affected by complex program changes. MLN Matters® Articles help explain critical provider information. Since 2004, CMS has issued over 5,100 articles.

Medicare Part A: Medicare coverage for inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Medicare Part B: Medicare coverage for doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as physical and occupational therapy and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Medicare Part C (Medicare Advantage) (MA): As part of The Medicare Prescription Drug, Improvement and Modernization Act (MMA), Medicare Advantage plans replaced the Medicare+Choice program, allowing Medicare beneficiaries to enroll in a managed care plan.

Medicare Part D: Medicare's prescription drug plan. Beneficiaries choose the drug plan and pay a monthly premium. The donut hole, as it is often referred to, is the gap between dollars spent that the beneficiary is responsible for and the full cost of drug therapy (often an issue in oncology cases or chronic illnesses).

Medicare Payment Advisory Commission (MedPAC): This commission was created in 1997 with the merger of the Physician Payment Review Commission and the Prospective Payment Assessment Committee and is charged to advise Congress on Medicare payment issues. It is to be politically neutral and none of its recommendations are mandates to CMS, although CMS often takes them into consideration during rule making.

Medicare Physician Fee Schedule (MPFS): The Centers for Medicare and Medicaid Services (CMS) uses the Medicare Physician Fee Schedule (MPFS) to reimburse physician services. The MPFS became effective January 1, 1992 and replaced the old "customary, prevailing, and reasonable" (CPR) charge system. The MPFS is funded by Part B and is composed of resource costs associated with physician work, practice expense and professional liability insurance.

Medicare Severity-Diagnosis-Related Group (MS-DRG): A new DRG system, called Medicare Severity DRGs (MS-DRGs), was adopted for use with Medicare's Inpatient Prospective Payment System. It became effective with discharges occurring on or after October 1, 2007. The MS-DRG structure was also adopted for use with the Long-Term Care Hospital Prospective Payment System (referred to as MS-LTC-DRGs). CMS replaced 538 DRGs with 745 new MS-DRGs, and instead of a two-tiered structure (with CC and without CC), MS-DRGs introduced a three-tiered structure: major complication/comorbidity (MCC), complication/comorbidity (CC), and no complication/comorbidity (non-CC). MCCs reflect secondary diagnoses of the highest level of severity.

Medicare Shared Savings Program (MSPB): The Medicare Shared Savings Program (Shared Savings Program) was established by section 3022 of the Affordable Care Act. The Shared Savings Program is a key component of the Medicare delivery system reform initiatives included in the Affordable Care Act and is a new approach to the delivery of health care. Congress created the Shared Savings Program to facilitate coordination



and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

Medicare Spending per Beneficiary (MSPB): Mandated by the ACA, the Hospital Value-Based Program must include this measure. It is reported as a ratio. Total Medicare Part A and Medicare Part B from three days prior to admission to 30 days post discharge. Prices are standardized and risk adjusted. Excludes Medicare Advantage, transfers, deaths and statistical outliers. MPSB Ratios are calculated based on a hospital's average spending compared to the national median: 1 = Spending is about the same as the national median; >1 = Spending is MORE than the national median; < 1 = Spending is LESS than the national median.

Merit-based Incentive Payment System (MIPS): This is established by MACRA (Medicare Access and CHIP Reauthorization Act of 2015) which repeals the SGR and improves Medicare payment for physician services. The MACRA consolidates the current programs into one program (MIPS) that streamlines and improves on the 3 distinct incentive programs; PQRS, VM and EHR. MIPS assesses performance in the categories of Quality, Advancing Care Information, Cost, and Improvement Activities and makes incentive payments based on an eligible clinician's or group's composite performance score in these categories.

Mid-Level Provider (MLP): See Advanced Practice Provider (APP).

N

National Cardiovascular Data Registry (NCDR®): The NCDR® is the American College of Cardiology's worldwide suite of data registries helping hospitals and private practices measure and improve the quality of cardiovascular care they provide. The NCDR encompasses six hospital-based registries and one outpatient registry, making it the most comprehensive outcomes-based quality improvement program in the United States. With growing domestic and international participation, there are currently more than 2,400 hospitals and nearly 1,000 outpatient providers participating in NCDR registries.

National Committee for Quality Assurance (NCQA): A not-for-profit organization that performs accreditation review of managed care plans, often the payers require the medical groups to meet the same criteria.

National Correct Coding Initiative (NCCI): A set of coding regulations to prevent fraud and abuse in physician and hospital outpatient coding; specifically addresses unbundling and mutually exclusive procedures.

National Coverage Determination (NCD): A nationwide determination of whether Medicare will pay for an item or service.

National Practitioner Data Bank (NPDB): Created in 1986 as a national central clearinghouse for malpractice actions taken against providers. Also maintains records of any actions concerning competence or conduct such as suspensions, censures and license revocations. Hospitals are required to request reports from the NPDB when a physician or dentist applies for staff privileges.

National Provider Identifier (NPI): A system for uniquely identifying all providers of health care services, supplies, and equipment, primarily for billing services under Medicare. Provided for under HIPAA, it replaced the Unique Physician Identifier Number (UPIN).

Non-compete Clause: Clause in employment agreements that prohibits the individual from practicing within the same region after leaving the business (e.g. medical practice). The agreement usually specifies the length of time and geographic area for which the clause is in effect. Also known as restrictive covenant.

Non-exempt Employees: Employees protected by the Fair Labor Standards Act regulations regarding minimum wage and overtime rules. This includes all employees other than those defined by the Fair Labor Standards Act as being exempt from the act's requirements.

Non-Patient Facing MIPS Eligible Clinicians: Eligible Clinicians who bill Medicare for 100 or fewer patient-facing services are considered to be Non-Patient Facing. These clinicians may be eligible for flexibility under the Merit-Based Incentive Payment System (MIPS).

Non-Physician Provider (NPP): Same as APP (Advanced Practice Provider)

O

Office of Inspector General (OIG): A division of the U.S. Department of Health and Human Services (HHS) that investigates issues of noncompliance in the Medicare and Medicaid programs such as fraud and abuse.

Office of the National Coordinator for Health Information Technology (ONC): The legal certifying body for all EHR's. Responsible for the certifying and testing of all EHR's and modules.

OPPS Hospital Outpatient Prospective Payment System: See HOPPS.

Outcome: The qualitative and/or quantitative result of medical treatment.

Outcomes Measurement: Formal process for measuring the effectiveness of medical treatment, the cost of treatment and patient satisfaction with treatment results.

Outliers: A patient who varies significantly from other patients in the same DRG (such as a longer or shorter length of stay, death, leaving against medical advice, etc.). Also used to describe healthcare providers whose services include unusually long lengths of stay, high number of diagnostic tests or other sources of high or low costs or utilization.

P

Patient Centered Medical Home (PCMH): The patient-centered medical home (PCMH) is a model of care that aims to transform the delivery of comprehensive primary care to children, adolescents and adults. Through the medical home model, practices seek to improve the quality, effectiveness and efficiency of the care they deliver while responding to each patient's unique needs and preferences.

Patient Portal: A secure entry point from the Internet to a practice's Web page, designed especially for patient use.

Pay for Performance: A program of financially structured incentives for practitioners and providers in exchange or as reward for the achievement of certain benchmarks of performance.

Payer: In healthcare, an entity that assumes the risk of paying for medical services. This is usually a health plan, an HMO or a self-insured employer but can also be an uninsured patient.

Payer Mix: The relative percentages of a practice's patients that are covered by government, self-pay, managed care and other third-party health care insurance organizations.

Partial Qualifying APM Participant (Partial QP): A Partial Qualifying APM Participant, or Partial QP, is a clinician who participates in an Advanced APM under the CMS Quality Payment Program, but does not meet the Qualifying Participant thresholds to receive the incentive payment under the Advanced APM track. A Partial QP may elect to participate in MIPS with flexible scoring, or may elect to not participate.

Pharmacy Benefit Management Company (PBM): A company that provides services such as claims processing, formulary management and drug utilization review.

Physician/Hospital Organization (PHO): An organizational entity that is formed between hospitals and physicians that allows for cooperative activity while giving a level of independence to the participating parties. This organizational structure is usually formed to pursue managed care contracts.

Physician Fee Schedule (PFS/MPFS): See MPFS

Physician Quality Reporting System (PQRS): A program that allows physicians and other healthcare professionals to report information to Medicare about the quality of care they provide to people with Medicare who have certain medical conditions. Clinicians who do not participate in PQRS annually are subject to a -2 percent penalty on Medicare Part B payments. The 2016 performance year/2018 payment year is the final year of PQRS. Starting with the 2017 performance year/2019 payment year, quality performance will be measured as part of the Merit-Based Incentive Payment System.

Picture Archiving and Communication System (PACS): Integrated computer system that obtains, stores, retrieves and displays digital images; including radiologic images.

Pioneer ACO Model: The Pioneer ACO Model is a CMS Innovation Center initiative designed to support organizations with experience operating as Accountable Care Organizations (ACOs), or in similar arrangements in providing more coordinated care to beneficiaries at a lower cost to Medicare. The Pioneer ACO Model will test the impact of different payment arrangements in helping these organizations achieve the goals of providing better care to patients, and reducing Medicare costs.

Population-Based Care: Population Health has been defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” It is an approach to health that aims to improve the health of an entire human population.

Precertification: Evaluation by the payer or financial intermediary to determine if specific medical services, such as hospitalization, are appropriate treatment for a patient. Also called prior authorization.

Prior Authorization: Procedure used in managed care to control utilization of services by prospective reviewing and approval.

Probe Audits: A CMS audit that is inpatient in origin. Used to educate hospitals on appropriate processes, used in the implementation of the 2 Midnight Rule.

Professional Component (PC): The physician's professional services used to evaluate the results of a diagnostic test. Within the Medicare physician fee schedule, a professional component is denoted with the status "26" to indicate that the professional services may be separately billed.

Program Safeguard Contractor (PSC): A Program Safeguard Contractor is under contract with the Centers for Medicare & Medicaid Services (CMS) to perform selected Medicare program integrity tasks.

Provider Based Billing (PBB): Provider based billing is the practice of charging for hospital employed physician services separately from building/facility overhead. Also commonly referred to as hospital outpatient department billing. Specific rules as to location and operational rules must be followed if billing under the HOPPS vs the PFS. Many states have different policies that must also be followed and some private insurances have implemented their own rules governing this billing.

Provider Enrollment, Chain and Ownership System (PECOS): An online system that allows you to manage your physicians, or other healthcare practitioners' provider files at Medicare.

Q

Qualified Clinical Data Registry (QCDR): A qualified clinical data registry (QCDR) is a reporting mechanism available for the Physician Quality Reporting System (PQRS) that began in 2014. A QCDR will complete the collection and submission of PQRS quality measures data on behalf of Eligible Professionals (EPs). A QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. To be considered a QCDR for purposes of PQRS, an entity must self-nominate and successfully complete a qualification process.

QCDR submissions are accepted for 2016 PQRS individual and group level reporting. QCDR submissions will also be accepted for reporting Merit-Based Incentive Payment System (MIPS) data.

Quality: Quality is a performance category under the Merit-Based Incentive Payment System (MIPS). The Quality category is based on elements of the Physician Quality Reporting System (PQRS) and requires eligible clinicians and groups to report quality measure data. Unlike PQRS, which was a pay for reporting system, eligible clinicians and groups will be awarded points based on their performance against measure benchmarks. For the 2017 performance/2019 payment year, Quality will count toward 60% of the MIPS score for most eligible clinicians and groups.

Quality Payment Program (QPP): The Quality Payment Program (QPP) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The QPP consists of two tracks – the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). The QPP provides incentives to clinicians and groups that provide high-quality value-based care to Medicare beneficiaries.

Quality and Resource Use Reports (QRUR): Reports used to calculate the Value Modifier (VM). Quality is currently determined by participation in PQRS. Cost is defined as the cost per capita as well as cost per index condition (CHF, Diabetes, CAD and COPD) and recently added MSPB - Medicare Spend per Beneficiary. Quality is also evolving using PQRS as well as the care coordination quality indicators. QRUR is reported by group and not by individual provider. 2017 Value Modifier and the 2015 Quality and Resource Use Reports were released in Fall 2016.

**R**

Readmission Reduction Program (RRP): Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. A readmission is defined as an admission to a subsection(d) hospital within 30 days of a discharge from the same or another subsection(d) hospital. Effective October 1, 2014 hospitals face a maximum 3% penalty. Like all Federal Quality programs, the measurements use a baseline year and a performance year. A complex algorithm is then configured to determine the incentive or payment adjustment. In 2015 FY there are five categories using a baseline period of July 1, 2010 thru June 30, 2013. The current conditions impacted include: CHF, MI, pneumonia, TH/TK and COPD. CABG will be the next condition to be added to the program.

Recovery Audit Program/Contractors (RAC): Congress created the Recovery Audit (RAC) program to help the Centers for Medicare and Medicaid Services (CMS) identify improper payments made by Medicare and Medicaid. The national Recovery Audit program is the product of a successful demonstration program that utilized Recovery Auditors to identify Medicare overpayments and underpayments to health care providers and suppliers in randomly selected states. The demonstration ran between 2005 and 2008 and resulted in over \$900 million in overpayments being returned to the Medicare Trust Fund and nearly \$38 million in underpayments returned to health care providers. As a result, Congress required the Secretary of the Department of Health and Human Services to institute a permanent and national Recovery Audit program to recoup overpayments associated with services for which payment is made under part A or B.

Regional Health Information Organization (RHIO): Groups of hospitals, physician practices and other health-related organizations in a geographic location or region of the country that are interconnected and would form a regional health Information network (RHIN).

Reinsurance: A type of protection purchased by HMOs from insurance companies specializing in underwriting specific risks for a stipulated premium. This becomes a cost of doing business for HMOs. Typical reinsurance risk coverages are: (1) individual stop-loss; (2) aggregate stop-loss; (3) out-of-area; and (4) insolvency protection. As HMOs grow in membership, they usually reduce their reinsurance coverage (and related direct costs) as they reach a financial position to assume such risks themselves.

Relative Value Units (RVUs): Nonmonetary, relative units of measure that indicate the value of health care services and resources consumed when providing different procedures and services. RVUs assign relative values or weights to medical procedures primarily for the purpose of the reimbursement of services performed. They are used as a standardized method of analyzing resources involved in the provision of services or procedures. There are many components in an RVU calculation and there are 2 main “types” of RVU’s—wRVU (often referred to as the pro fee); and the total RVU which includes the technical component of the payment.

Relative Value Update Committee (RUC): An American Medical Association specialty committee formed in 1991 to make recommendations to CMS on the relative values to be assigned to new or revised CPT codes.

Report Cards: Performance reports that evaluate the operation, services or processes of a business or organization. May be used for internal purposes or released publicly. Health care report cards evaluate the care provided to patients by a provider. For example, one of Medicare’s report cards is referred to as the QRUR - Quality Resource and Utilization Report.



Resource-Based Relative Value Scale (RBRVS): The relative value scale was developed for CMS for Medicare reimbursement. Relative values are assigned to CPT codes on the basis of the resources needed to perform the service.

S

Safe Harbor: A set of federal regulations providing criminal and civil protection for certain health care business practices entered into by hospitals and physicians when specific requirements are met.

Site of Service (SOS): Payment differentials based on where a service is performed. There is a facility based fee - normally a hospital or Ambulatory Surgery Center (ASC) and there is a non-facility fee - normally a physician office or clinic. Accurate coding is critical to appropriately bill.

Skilled Nursing Facility (SNF): A health care institution that meets federal criteria for Medicaid and Medicare reimbursement for nursing care.

Stark Law: Also known as federal physician self-referral laws, the law prohibits a physician from referring a Medicare or Medicaid patient for “designated health services” in which the physician or physician’s immediate family members have an ownership, investment or compensation interest, unless an exception applies.

Sunshine Act: The Sunshine Act requires manufacturers of drugs, medical devices, biological and medical supplies covered by the three federal health care programs (Medicare, Medicaid and State Children’s Health Insurance Program) to collect and track all financial relationships with physicians and teaching hospitals and to report these data to the Centers for Medicare and Medicaid Services (CMS). The goal of the law is to increase the transparency of financial relationships between health care providers and pharmaceutical manufacturers and to uncover potential conflicts of interest.

Supplemental QRURs: The QRUR Supplementary Exhibits complement the per capita cost and quality information provided in the QRURs. They supplement the information provided in the QRURs, so that you have a better sense of your patient population, your patient’s use of healthcare services and awareness of the other providers involved in your patient’s care. Specifically, these supplementary exhibits build on the information in the QRUR and present: (1) Information about the physician and non-physician eligible professionals billing under your TIN; (2) Information about the Medicare beneficiaries attributed to you; (3) Data on the hospital admissions for your attributed beneficiaries; (4) Data on the Medicare beneficiaries attributed to you for the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure; (5) Information on individual eligible professional performance on the 2013 PQRS measures (if eligible professionals submitted any under your TIN); and (6) A summary of your 2013 GPRO earned incentive (if you were eligible to receive one).

Sustainable Growth Rate (SGR): The update formula used to establish a target rates for growth of the Medicare program. The SGR takes into account estimates of the percentage change in physicians’ fees, the average number of Medicare beneficiaries, growth in the gross domestic product (GDP) and costs to the Medicare program due to changes in law or regulation. These four estimates are used to create a percentage by which the previous year’s conversion factor is modified.



Systematized Nomenclature of Medicine Clinical Terms SNOMED CT®: A comprehensive clinical vocabulary used in many EHR systems to encode clinical terms for use in clinical decision support systems. It was developed by the College of American Pathologists and is freely distributed through SNOMED International under special license from the U.S. National Library of Medicine.

T

Tax Identification Number (TIN): A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. Billing under a TIN has become the cornerstone of many of the quality programs as the NPI and TIN numbers carry critical importance in the outcomes. Managing by TIN is crucial.

Transitional Care Management (TCM): TCM includes services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home or assisted living). It has two main codes and requires follow up post discharge. Billing cannot occur until 30 days post discharge and can only be billed by one provider.

Two-Midnight Rule: The two-midnight policy essentially assumes that an admission was appropriate if a patient's stay spanned two midnights and that outpatient observation status was appropriate if it did not. The policy was conceived to address a spike in observation stays believed to be inspired by hospitals' fear that Medicare's audit contractors would challenge their admissions. The CMS originally announced the two-midnight policy in 2013. But enforcement of the rule has been repeatedly delayed through legislative and regulatory action. The most recent postponement until end of April allows Congress time to pass the package repealing Medicare's sustainable growth-rate formula when it reconvenes on April 13.

V

Value-Based Purchasing (VBP): A CMS program that links provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Value Modifier (VBPM): The Value Modifier (VM) provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared to the cost of care during a performance period. (In the future, the Value Modifier will be used to adjust Medicare PFS payments to non-physician eligible professionals (EPs), in addition to physicians.) An Eligible Professional (EP) includes physicians and APPS. The VM is an adjustment made on a per claim basis to Medicare payments for items and services under the Medicare PFS. It is applied at the Taxpayer Identification Number (TIN) level to physicians (and beginning in 2018, to non-physician EPs) billing under the TIN. In 2015, physicians in groups of 100 or more EPs who submit claims to Medicare under a single tax identification number will be subject to the VM, based on their performance in calendar year 2013. In 2016, the VM will be applied to groups of 10 or more EPs based on 2014 performance and in 2017, the VM will be applied to physician solo practitioners and physicians in groups of two or more EPs based on performance in 2015.



Volume to Value (V2V): A move to use measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity, of care they give patients. HHS has set clear goals and timeline for shifting Medicare reimbursements from volume to value. Specifically, HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

W

Web Interface (WI): Refers to the interaction between a user and software running on a Web server.

Work RVUs (wRVU): The physician work component of the total RVU for all procedures performed by the medical practice, for both fee-for-service and capitation patients and for all payers. See also Relative Value Units (RVUs).

Z

Zone Program Integrity Contractors (ZPIC): Zone Program Integrity Contractors (ZPICs) were created to perform program integrity functions for the Medicare Integrity Program or MIP. The primary goal of ZPICs is to investigate instances of suspected fraud, waste and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC. The program's use of statistical data sampling and extrapolation methods enable them to recoup millions of dollars if not challenged.