ABC’s of Acronyms
Editor’s note: The following listing will help you through the health care acronym maze. The information is provided by Erin O’Donnell, an Associate with PricewaterhouseCoopers.

AAPCC - Adjusted average per capita cost. CMS/HCFA's best estimate of the amount of money it costs to care for Medicare recipients under fee-for-service Medicare in a given area. The AAPCC is made up of 142 different rate cells; 140 of them are factored for age, sex, Medicaid eligibility, institutional status, working aged, and whether a person has both Part A and Part B of Medicare. The 2 remaining cells are for individuals with end stage renal disease.

ABN - Advance Beneficiary Notice (ABN) is a waiver that a provider has a patient sign confirming the patient's understanding that certain provided services may not be reimbursable under Medicare and therefore are the patient's responsibility.

ACC - Ambulatory Care Center (ACC) - The purpose of some ACCs is to provide quality care to patients requiring same-day surgery as well as to provide care and observation for specific outpatient procedures, including chemotherapy and gastroenterology. Services are provided to one-day surgical patients and nonsurgical outpatients. Patients treated in the ACC include pediatric, adolescent, adult and geriatric. For more info visit http://wupa.wustl.edu/record/archive/1997/12-11-97/1164.html

ACER – Annual Contractor Evaluation Report (ACER) is HCFA's formal evaluation report of the contractor's performance for the fiscal year. It is based upon results of the Contractor Performance Evaluation Program (CPEP) reviews, along with results of other special evaluations which are considered when evaluating contractor performance. The reviews measure the degree to which each contractor meets HCFA's performance criteria and standards. The scores in the ACER show the level of performance achieved by the contractor for each standard and criterion. To read more about ACER, visit http://www.hcfa.gov/pubforms/23%5From/r21005.htm#_1_2

ACR - Adjusted Community Rate (ACR) - Health plans and insurance companies estimate their ACRs annually and adjust subsequent year supplemental benefits or premiums to return any excess Medicare revenue above the ACR to enrollees. This are the estimated payment rates that health plans with Medicare risk contracts would have received for their Medicare enrollees if paid their private market premiums, adjusted for differences in benefit packages and service use. To read more visit: http://www.os.dhhs.gov/progorg/oas/whatsnew.html

ADPL - Average Daily Patient Load is the average number of inpatients, including live births, in the hospital, receiving care each day during a reported period. Want more info - visit www.pasba.amedd.army.mil/amis/meprs/meprsbackgrd.html

APGs - Ambulatory Patient Groups or APGs are a patient classification system designed to explain the amount and types of resources consumed in an ambulatory visit. There are 290 APGs in the current version (Version 2.0) and they encompass the full range of services delivered in the ambulatory setting, including same day surgery units, hospital emergency rooms and outpatient clinics. APGs are assigned
using ICD-9-CM diagnoses and HCPCS procedure codes - specifically, CPT and Level II HCPCS. APGs use procedure - not diagnosis - as the initial classification variable.

All patients with a significant procedure or therapy are assigned to a procedure-related APG. A significant procedure or therapy is a procedure that is normally scheduled, constitutes the main reason for the visit and dominates the majority of resources consumed during the visit. Patients with no significant ambulatory procedures who received medical services are assigned to a medical APG. To be assigned to a medical APG, an “Evaluation and Management” procedure code must be present for the visit. Patients with no significant procedures and no “Evaluation and Management” code are classified as receiving “ancillary services only”. The category “ancillary services” includes tests ordered by the primary physician to assist in patient diagnosis and treatment, as well as procedures that increase the time and resources used during a visit, but do not dominate the visit. To read more about APG’s visit [http://www.hssweb.com/Insights/insight12.htm](http://www.hssweb.com/Insights/insight12.htm)

CAH - Critical Access Hospital was created by the Medicare Rural Hospital Flexibility. A CAH is a limited service hospital that is eligible for Medicare reimbursement and may be an attractive alternative to the current hospital licensing standards. To qualify as a CAH, the hospital must meet the following criteria:
- Non-profit or public hospital that is open and operating
- Located 35 miles from another hospital (15 miles in mountainous terrain or areas with only secondary roads) or certified by the State as being a necessary provider
- Bed size limit of 15 except in swing-bed facilities, which may have up to 25 inpatient beds that can be used interchangeably, provided not more than 15 acute care beds are used at any one time
- Maximum length of stay of 96 hours unless there is inclement weather, another emergency, or approval for extended stays is granted by the state
- Make available 24 hour emergency services and nursing services but need not meet all the staffing and service requirements that apply to a full service hospital
- Participate in a rural health network, which is defined as an organization consisting of at least one CAH and at least one full-service hospital where participants have entered into specific agreements regarding patient referral and transfer, communication, and patient transportation
- Establish credentialing and quality assurance agreements with at least one hospital that is a member of a network, PRO or equivalent, or an entity identified in the rural health plan of the state
- Inpatient care may be provided by a mid-level practitioner (physician assistant or nurse practitioner) under remote supervision of a physician
- Reimbursed on a reasonable cost basis for inpatient and outpatient services provided to Medicare beneficiaries
For more information visit [http://www.health.state.mn.us/divs/chs/rhpc/CAH/questions.html](http://www.health.state.mn.us/divs/chs/rhpc/CAH/questions.html)

CAHPS - Consumer Assessment of Health Plan Survey. An initiative by the federal government for Medicare & Medicaid, the aim of which is to develop a set of satisfaction surveys built off a core of standardized items and supplemented by additional targeted elements to make the surveys both adaptable to different sub-population and suitable for making some cross-group comparisons. Special Medicaid survey modules have been developed that accommodate educational, linguistic, and cultural differences in this population.
**CHAMPUS** - Civilian Health and Medical Program of the Uniformed Services is a federal program providing healthcare coverage to families of military personnel, military retirees, certain spouses and dependents of such personnel, and certain others. To read more about CHAMPUS visit [http://www.ndw.navy.mil/html/champus.html](http://www.ndw.navy.mil/html/champus.html)

**CMP** - Competitive Medical Plan is a federal designation that allows a health plan to obtain eligibility to receive a Medicare risk contract without having to obtain qualification as an HMO. To read more about CMP's visit [www.hcfa.gov](http://www.hcfa.gov)

**CMS** – Centers for Medicare & Medicaid Services, previously known as the Health Care Financing Administration (HCFA), is the agency that administers the Medicare and Medicaid programs. For more information go to [http://www.hcfa.gov](http://www.hcfa.gov)

**CPR** - Customary, Prevailing and Reasonable is the current method of paying physicians under Medicare. Payment for a service is limited to the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge for the service, or (3) the prevailing charge for that service in the community. CPR is similar to UCR, the Usual, Customary, and Reasonable system used by private insurers.

**CWW** - Clinic without walls - Practitioners form CWWs and practice without walls (PWWs) when they want the economies of scale and bargaining power offered by centralizing some administrative functions, but, still choosing to practice separately. CWW’s are similar to an independent practice association and identical to a PWW. Many of these were formed to allow practitioners the ability to effectively contract with managed care.

**DME** - Durable Medical Equipment are items of medical equipment owned or rented which are placed in the home of an insured to facilitate treatment and/or rehabilitation. DME generally consist of items which can withstand repeated use. DME is primarily and customarily used to serve a medical purpose and is usually not useful to a person in the absence of illness or injury.

**DRG** - Diagnosis Related Group (DRGs) are an American patient classification system used to define different types of inpatients. They form a "manageable, clinically coherent set of patient classes that relate a hospital's case mix to the resource demands and associated costs experienced by the hospital" (DRG Definitions Manual, 1994). Developed at Yale University (under contract to the Health Care Financing Administration), this classification system has been used by Medicare since 1983 as part of the Prospective Payment System for funding hospitals. Visit [http://www.umanitoba.ca/centres/mchpe/concept/dict/DRG_overview.html](http://www.umanitoba.ca/centres/mchpe/concept/dict/DRG_overview.html)

**DSH** - Disproportionate Share Adjustment is a payment adjustment under Medicare's PPS (Prospective Payment System) for Medicaid utilization at hospitals that serve a relatively large volume of low-income patients, pregnant patients or other patients under the Medicaid program. Disproportionate share has been a continuing topic in Congress. Some wish to eradicate to reduce costs. Rural facilities, teaching hospitals and hospitals in poverty areas claim that the reduction or elimination of disproportionate share payments would cause hospitals to close, move or reduce care to the poor. DSH is a method whereby the government recognizes that hospitals treating high percentages of Medicaid payments would not be able to cover their costs and remain in service without additional government subsidy.
**EPO - Exclusive Provider Organization** is a plan, which limits coverage of non-emergency care to contracted health care providers. It operates similar to an HMO plan but is usually offered as an insured or self-funded product. Sometimes looks like a managed care organization that is organized similarly to a PPO [preferred provider organization] in that physicians do not receive capitated payments, but the plan only allows patients to choose medical care from network providers. If a patient elects to seek care outside of the network, then he or she will usually not be reimbursed for the cost of the treatment. EPOs typically use a small network of providers and has primary care physicians serving as care coordinators (or gatekeepers). Typically, an EPO has financial incentives for physicians to practice cost-effective medicine by using either a prepaid per-capita rate or a discounted fee schedule, plus a bonus if cost targets are met. Most EPOs are forms of POS [point of service] plans because they pay for some out-of-network care. To read more check out: [http://www.behavenet.com/capsules/reimb/epo.htm](http://www.behavenet.com/capsules/reimb/epo.htm)

**ERISA - Employee Retirement Income Security Act**
Established in 1974, ERISA set up plan design, funding, and administration requirements for employee pension plans to protect the rights of plan participants and beneficiaries including preempting certain state laws relating to employee benefit plans, including medical plans self-insured by employers. Visit [http://www.harp.org/erisatoc.htm](http://www.harp.org/erisatoc.htm)

**GAO - General Accounting Office**is the "investigative" arm of Congress. The GAO exists to support the Congress in meeting its Constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds, evaluates federal programs and activities, and provides analyses, options, recommendations, and other assistance to help the Congress make effective oversight, policy, and funding decisions. In this context, GAO works to continuously improve the economy, efficiency, and effectiveness of the federal government through financial audits, program reviews and evaluations, analyses, legal opinions, investigations, and other services. GAO's activities are designed to ensure the executive branch's accountability to the Congress under the Constitution and the government's accountability to the American people. GAO is dedicated to good government through its commitment to the core values of accountability, integrity, and reliability.” Visit [http://www.gao.gov/](http://www.gao.gov/)

**HCPCS - HCFA Common Procedure Coding System**
A set of codes used by Medicare that describes services and procedures; HCPCS Level I codes are CPT codes, Level II codes are for supplies and other non-CPT codes, and Level III are locally set codes. Want to read more? Visit [http://www.hcfa.gov/medicare/hcpcs.htm](http://www.hcfa.gov/medicare/hcpcs.htm)

**MLR - Medical Loss Ratio** is the cost ratio of total benefits used compared to revenues received. Usually referred to by a ratio, such as 0.96--which means that 96% of premiums were spent on purchasing medical services. The goal is to keep this ratio below 1.00--preferably in the 0.80 range, since the MCO's or insurance company's profit comes from premiums. Currently, successful HMOs do have MLRs in the 0.70-0.80 range. The ratio between the cost to deliver medical care and the amount of money that was taken in by a plan. Insurance companies often have a medical loss ratio of 96 percent or more: tightly managed HMOs may have medical loss ratios of 75 percent to 85 percent, although the overhead (or administrative cost
ratio) is concomitantly higher. To read more about MLR, and how to use MLR visit [http://www.physicianrecruiter.com/Dept/retention/9961.htm](http://www.physicianrecruiter.com/Dept/retention/9961.htm)

**NPI - National Provider Identifier** The NPI is a unique identification number issued to each health care provider. It will be used by all health plans. “Health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions specified by HIPAA. The NPI was proposed as an 8-position alphanumeric identifier. However, many commenters preferred a 10-position numeric identifier with a check digit in the last position to help detect keying errors. The NPI contains no embedded intelligence; that is, it contains no information about the health care provider such as the type of health care provider or State where the health care provider is located.” For FAQ’s about NPI, visit [http://aspe.hhs.gov/admnsimp/faqnpi.htm](http://aspe.hhs.gov/admnsimp/faqnpi.htm)

**NUBC - National Uniform Billing Committee** (NUBC) was brought together by the American Hospital Association (AHA) in 1975 and it includes the participation of all the major national provider and payer organizations. The NUBC was formed to develop a single billing form and standard data set that could be used nationwide by institutional providers and payers for handling health care claims. Visit [http://www.nubc.org/history.html](http://www.nubc.org/history.html)

**PRRB - Provider Reimbursement Review Board** is an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination of its fiscal intermediary or HCFA. A decision of the Board may be affirmed, modified, reversed, or vacated and remanded by the HCFA Administrator within 60 days of notification to the provider of that decision. Visit [http://www.hcfa.gov/regs/prrb.htm](http://www.hcfa.gov/regs/prrb.htm)

**QMS - Quality Management System** is an annual review program applicable to activities you conduct and decisions you make as part of the Contractor Performance Evaluation Program (CPEP) process. It ensures consistent, accurate, and timely CPEP data for use in the contract management process. The QMS is a peer review process and, to the extent possible, allows evaluation of your performance by committees with substantial regional office (RO) participation.

1050.1 **Overall Structure.**--The QMS is divided into three sections: Systems Review, Methodology Review and Quality Review.

- The Systems Review measures your compliance with CPEP review procedures regarding timeliness and data consistency, and timeliness of first level appeals review.
- The Methodology Review is a review of application of CPEP instructions to the method of evaluation (MOE).
- The Quality Review is a review of the full scope of CPEP activities (e.g., review methodology and quality of decisions).

Each review is conducted independently. The results of reviews under any one section do not affect results of reviews under any other section. Visit [http://www.hcfa.gov/pubforms/23%5From/r21005.htm#_1_13](http://www.hcfa.gov/pubforms/23%5From/r21005.htm#_1_13)

**SCHIP - State Children's Health Insurance Program** (SCHIP) gives grants to states to provide health insurance coverage to uninsured children up to 200% of the federal poverty level (FPL). States may provide this coverage by expanding Medicaid or by expanding or creating a state children’s health insurance program. However, states
do not have to participate, and they can also choose to wait up to three years to implement the program without losing any funds. Visit 

**SFR** - Significant Financial Risk. A term used by HCFA that refers to the total amount of a physician's income at risk in a Medicare HMO. Such financial risk is considered "significant" when it exceeds a certain percentage of the total potential income that physician could receive under the reimbursement program. SFR most commonly is defined as any physician incentive payment program that allows for a variation of more than 25% between the minimum and the maximum amount of potential reimbursement.

**SUBC** - State Uniform Billing Committee is a state specific affiliate of the NUBC (National Uniform Billing Committee). An organization, chaired and hosted by the American Hospital Association, that maintains the UB-92 hardcopy institutional billing form and the data element specifications for both the hardcopy form and the 192-byte UB-92 flat file EMC format. The NUBC (National Uniform Billing Committee) has a formal consultative role under HIPAA for all transactions affecting institutional health care services.

**UCR** - Usual, Customary and Reasonable - UCR is the conceptual reason for limiting payment. The use of fee screens to determine the lowest value of provider reimbursement based on: (1) the provider's usual charge for a given procedure, (2) the amount customarily charged for the service by other providers in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case. Most health plans provide reimbursement for usual and customary charges, although no universal formula has been established for these rates.

**WHO** - World Health Organization is a specialized agency of the United Nations, established in 1948, with its headquarters at Geneva. WHO admits all sovereign states (including those not belonging to the United Nations) to full membership, and it admits territories that are not self-governing to associate membership. There are regional organizations in Africa, the Eastern Mediterranean, Southeast Asia, Europe, the west Pacific, and the Americas. WHO has made notable strides in checking polio, leprosy, cholera, malaria, and tuberculosis, and sponsors medical research on tropical and other diseases. WHO has drafted conventions for preventing the international spread of disease, such as sanitary and quarantine requirements, and has given attention to the problems of environmental pollution. To read more about the WHO, visit [www.who.org](http://www.who.org).

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