

AMCLC 2009
Health Policy and Economics Acronyms

ABMS The American Board of Medical Specialists – the ABMS a not-for-profit organization, assists 24 approved medical specialty boards in the development and use of standards in the ongoing evaluation and certification of physicians.

ABN Advanced Beneficiary Notice – an ABN is a written notice to Medicare patients notifying them that:-

- 1) Medicare may deny payment for that specific procedure or treatment, and
- 2) The patient may be personally responsible for full payment if Medicare denies payment.

ABR The American Board of Radiology - certifies that medical students have acquired, demonstrated, and maintained a requisite standard of knowledge, skill and understanding essential to the practice of Diagnostic Radiology, Radiation Oncology and Radiologic Physics.

AHA American Hospital Association - the American Hospital Association is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities.

APC Ambulatory Payment Classification - all services paid under the hospital outpatient prospective payment system are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC.

ARRA American Recovery and Reinvestment Act of 2009 - is an economic stimulus package enacted by Congress and signed into law by President Barack Obama on February 17, 2009. The Act includes federal tax relief, expansion of unemployment benefits and other social welfare provisions, and domestic spending in education, health care, and infrastructure, including the energy sector.

ASC Ambulatory Surgical Center – a facility that provides surgical services as approved by Medicare. Medicare has established a separate payment system for these sites based on 65% of the payment under the hospital outpatient prospective payment system.

ASP Average Sales Price – Average Sales Price is the weighted average of all the sales of the drugs to all purchasers. The Average Sales Price methodology uses quarterly drug pricing data submitted to Medicare by drug manufacturers.

AWP Average Wholesale Price - Average Wholesale Price was the price that Medicare paid to doctors for drugs until 2005 and was replaced by ASP.

BBA Balanced Budget Act of 1997 - The Balanced Budget Act of 1997, was signed into law on August 5, 1997. Among many other things, the Act contained major Medicare reforms to address health care fraud and abuse.

BBRA Balanced Budget Refinement Act – The Balanced Budget Refinement Act was signed into law in 1999. The Act effectively designates a portion of projected budget surpluses for use in restoring funding to the Medicare program that had been eliminated by the Balanced Budget Act of 1997.

BIPA Beneficiary Improvement and Protection Act - A regulation that came into effect July 1, 2005 gives rights to patients enrolled in traditional, fee-for-service Medicare and provides Medicare beneficiaries the ability to appeal provider termination of services.

CAC Carrier Advisory Committee - The ACR Radiology, Radiation Oncology, and Nuclear Medicine Carrier Advisory Committee (CAC) Network Representatives advocate on behalf of radiology and all radiology subspecialties for fair reimbursement policies at the local Medicare level. By reviewing and commenting on Local Coverage Decisions (LCDs) and policy changes before they are implemented, the CAC networks help ensure members are appropriately reimbursed for medically reasonable and necessary services provided to Medicare patients.

CCR Cost to Charge Ratio - Cost to Charge Ratio is an approach used when calculating hospitals costs. It requires the use of the Medicare hospital cost reports in combination with the claims data and contributes to setting the payment rates for APCs.

CF Conversion Factor - The Medicare conversion factors are dollar multipliers that converts the geographically adjusted number of relative value units (RVUs) or APCs for each service in the Medicare physician fee schedule and hospital outpatient prospective payment system into a dollar payment amount. The CFs are updated on an annual basis (or sometimes biannual) according to a formula specified by statute.

CMS Centers for Medicare and Medicaid Services (formerly known as HCFA) – is a U.S. federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.

CPT Current Procedural Terminology - A systematic listing of codes for procedures and services performed by physicians. Each procedure or service is identified with a five-digit code.

DMEPOS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies- these items are usually paid separately under a fee schedule.

DRA The Deficit Reduction Act - The DRA caps the technical component reimbursement for physician office imaging to the lesser of the Hospital Outpatient Prospective Payment System or Medicare Fee Schedule payment.

DRG Diagnosis Related Group - is a system to classify hospital cases into one of approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use, developed for Medicare as part of the inpatient prospective payment system.

E/M Evaluation and Management – patient evaluation and management services that a physician provides during a patient’s office, hospital, or other visit or consultation. This method is based primarily on type of history, examination, and medical decision making.

ERISA Employee Retirement Income Security Act - this originally drafted to provide greater protection to the fiscal interests of participants of private employee benefit plans by establishing a uniform set of standards by which most employer-sponsored plans must abide.

GAO Government Accountability Office - The U.S. Government Accountability Office is an independent, nonpartisan agency that works for Congress. Often called the "congressional watchdog," GAO investigates how the federal government spends taxpayer dollars.

GPCI Geographic Practice Cost Index - the purpose of these adjustments is to account for geographic variations in the costs of practicing medicine in different areas within the country under the Medicare Physician Fee Schedule.

HCPCS Healthcare Common Procedural Coding System (pronounced hick picks) - is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT). There are three levels of HCPCS codes:

Level I - Level 1 codes include five-digit codes and two-digit modifiers, both with descriptive terms for reporting services performed by physicians and other health care providers. *Level II* –Level II codes are used primarily to identify products, supplies, and services not included in CPT codes. *Level III – Local Codes* – Level III are the temporary assignment of codes for procedures and new technologies, that are maintained by individual state Medicare carriers.

HHS Department of Health and Human Services - is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

HOPPS Hospital Outpatient Prospective Payment System - section 4523 of the Balanced Budget Act of 1997 provides authority for CMS to implement a prospective payment system under Medicare for hospital outpatient services, certain Part B services

furnished to hospital inpatients who have no Part A coverage, and partial hospitalization services furnished by community mental health centers.

HOP QDRP Hospital Outpatient Quality Data Reporting Program - as required by law, hospitals are mandated to report data for services on the quality of hospital outpatient care using standardized measures of care to receive the full annual update to their OPSS payment rate. In 2009, the program includes 4 outpatient imaging measures. The 4 measures are: Use of Contrast- Abdomen CT, Use of Contrast – Thorax CT, MRI Lumbar Spine for Low Back Pain and Mammography Recall Rate.

ICD – 9 ICD-9 is an acronym used in the medical field that stands for *International Classification of Diseases, ninth revision*. The ICD is used to provide information on a claim about the patients signs, symptoms and/or diagnosis.

IDTF Independent Diagnostic Testing Facility – An IDTF is independent of a physicians office or hospital. It may be a fixed location or mobile entity.

LCD A Local Coverage Determination (LCD) - as established by the Benefits Improvement and Protection Act for Medicare, is a decision by a fiscal intermediary (Part A insurance contractor) or carrier (Part B insurance contractor) whether to cover a particular medical service based on whether the service is reasonable and necessary.

MedCAC The Medicare Evidence Development & Coverage Advisory Committee - (MEDCAC) was established to provide independent guidance and expert advice to CMS on specific clinical topics. The MedCAC reviews and evaluates medical literature, technology assessments, and examines data and information on the effectiveness and appropriateness of medical items and services that are covered under Medicare, or that may be eligible for coverage under Medicare.

MedPAC Medicare Payment Advisory Commission - the Medicare Payment Advisory Commission is an independent Congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program.

MEI Medicare Economic Index - an index introduced in 1976 that is intended to measure the annual growth in physicians' practice costs and general inflation in the cost of operation a medical practice.

MMA Medicare Prescription Drug Improvement and Modernization Act - this Act was signed into law on December 8, 2003 by President Bush. This landmark legislation provides seniors and individuals with disabilities with a prescription drug benefit, more choices, and better benefits under Medicare.

MPFS Medicare Physician Fee Schedule - Medicare Physician Fee Schedule relates payment for physician work and practice expenses to the actual resources used to

provide medical services rather than physicians' historical charges. A fully resource-based fee schedule reflects all relative resources involved in delivering a service.

NCD National Coverage Determination - (NCDs) is Medicare's nationwide decision process to determine which select medical items or services may be eligible for coverage under the Medicare program. These decisions are made through an evidence-based process, with input from MedCAC and opportunities for public participation.

NPV Net Present Value - is the real value of a stream of cash flows in the future. The cash flows are discounted by the cost of capital or discount rate to bring them down to today's value

OBRA Omnibus Budget Reconciliation Act – the congressional legislation creating Medicare physician payment reform that provided for the Medicare Physician Fee Schedule based on a RBRVS, which included three components: physician work, practice expense, and professional liability insurance.

P4P Pay-for-Performance – a reimbursement model that compensates physicians for meeting selected quality and efficiency measures. Providers under this arrangement are rewarded for meeting these pre-established measures for delivery of healthcare services.

PC Professional Component – the professional component is the payment for physician services used to provide all medical services in the Medicare program in all practice settings. The professional component is based on three components which are physician work, indirect practice expenses and malpractice expense.

PPS Prospective Payment System - a Prospective Payment System is a method of reimbursement in which Medicare payment is made based on previous years data to determine the current years payment rates.

PQRI Physician Quality Reporting Initiative – the 2006 Tax Relief and Health Care Act (TRHCA) required the establishment of a physician quality reporting system including incentive payments for those who satisfactorily report data and quality measures.

RBMA Radiology Business Management Association - is a not-for profit association of radiology business management professionals.

RBRVS Resource-Based Relative Value Scale – assigns procedures performed by a physician or other medical provider a relative value which is based in relativity to one base code in the Medicare Physician Fee Schedule. There are separate relative values for physician work practice expense and malpractice value for both physicians and practice expenditures in the office setting.

Physician Work Relative Value Unit (PW RVU) - reflect the relative levels of time and intensity associated with physicians providing the service and account for more than 50 percent of the total payment associated with a service the professional component. By statute, all work RVUs must be examined no less often than every five years.

Practice Expense Relative Value Unit (PE RVU) - are the direct and indirect costs related to maintaining a practice such as renting office space, buying supplies and equipment, staff costs, costs of billing, CME, and other.

Malpractice Relative Value Unit (MP RVU) - Malpractice RVUs represent the remaining portion of the total payment associated with a service. The MP RVUs are based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the States, the District of Columbia, and Puerto Rico.

RVU Relative Value Unit – the unit of measure for the Medicare RBRVS. To obtain a payment amount, the RVUs must be multiplied by a dollar conversion factor.

RUC The Relative Value Update Committee (RUC) is responsible for valuing physician work for new and revised CPT® codes.

SGR Sustainable Growth Rate – is the formula that calculates the conversion factor or dollar multiplier for payment under the Medicare Physician Fee Schedule. The Sustainable Growth Rate is calculated based on medical inflation, the projected growth in the domestic economy, projected growth in the number of beneficiaries in fee-for service Medicare, and changes in law or regulation.

TC Technical Component – this represents the cost of clinical time, equipment and supplies to perform that service or procedure. This modifier corresponds to the equipment/office setting part of a given service or procedure.

TRHCA Tax Relief and Health Care Act of 2006 - President Bush signed into law the Tax Relief and Health Care Act of 2006 (TRHCA) on December, 2006. With an estimated cost of \$45 billion over 10 years, the new legislation includes extensions of several tax incentives, changes to health savings accounts (HSAs), and mandates PQRI.

USPSTF U.S. Preventive Services Task Forces - is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.

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