

## GLOSSARY

### A

**Abuse** – When providers supply services or products that are not medically necessary and/or do not meet professional standards.

**Abuse (Personal)** – When another person knowingly does something that causes you mental or physical harm or pain.

**Access** – Your ability to get needed medical care and services.

**Accessibility of Services** – Your ability to get medical care and services when you need them.

**Accreditation** – A seal of approval from a private independent group. Being accredited means that certain quality standards have been met.

**Act / Law / Statute** – Term for legislation that has passed through Congress and has been signed by the President, or passed over the President’s veto, and has become law.

**Activities of Daily Living (ADL)** – Activities you usually do during a normal day. Although definitions differ, activities usually considered to be everyday activities include walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. Also see “Custodial Care.”

**Actual Charge** – The amount a physician or other health care provider bills a patient for a particular medical service or procedure. The actual charge may differ from the Medicare-approved amount or amount approved by other insurance programs.

**Acute Care** – Medical care designed to treat or cure disease or injury, usually within a limited time period. Acute care usually refers to physician and/or hospital services of less than three (3) months in length.

**Administrative Law Judge (ALJ)** – A hearing officer who presides over appeal conflicts between providers of service or beneficiaries, and Medicare contractors.

**Admitting Physician** – The doctor responsible for admitting you to a hospital or other inpatient health facility.

**Advance Beneficiary Notice of Noncoverage (ABN)** – A notice that a doctor or supplier should give a person with Medicare to sign if it is believed that Medicare does not consider the service medically necessary and Medicare will not pay for it. If you do not get an ABN to sign before you get the service from your provider of service (doctor), and Medicare does not pay for that service, then you do not have to pay for the service. If your doctor does give you an ABN to sign and Medicare does not pay for it, you will be responsible to pay for the service. (This form could also be given by a home health agency or hospital.)

**Advance Coverage Decision** – A determination that a Private Fee-for-Service Plan, a type of Medicare Advantage Plan, makes on whether or not it will pay for a certain service.

**Advance Directive**– A legal document that outlines how you want medical decisions made if you can no longer communicate your wishes. A health care directive may include a health care proxy and a living will. Completed while a person has decision making capacity, a health care proxy names someone who is designated as the health care agent authorized to make medically related decisions if, in the future, the person completing the document lacks capacity. A living will outlines the types of treatments that the person would or would not want if seriously ill and not expected to recover. See Health Care Proxy.

**Advocate** – A person who gives you support or protects your rights.

**Adult Day Care** – A daytime community-based program for functionally impaired adults that provides a variety of health, social, and related support services in a protective setting.

**Affiliated Provider** – A health care provider (physician) or facility that is paid by a health plan to give services to plan members.

**Ambulatory Care** – Health services that do not require an overnight hospital stay.

**Ambulatory Payment Classifications (APC)** – APCs are used to determine the amount that Medicare reimburses hospitals for outpatient services. It is part of the Outpatient Prospective Payment System (OPPS). The hospital is paid a fixed amount based on the APC code for the patient.

**Ambulatory Surgical Center** – A separate part of a hospital that does outpatient surgery.

**Ancillary Services** – Professional services by a hospital or other inpatient health program. These may include X-ray, drug, laboratory, or other services.

**Anesthesia** – Drugs that a person is given before surgery so he or she will not feel pain.

**Appeal** – People with Medicare have the right to request a review of a denied claim, and if not satisfied with the review, to appeal to a higher level review. See Medicare Appeal.

**Appeals Process** – If you disagree with the denial or decision about your health care coverage you can have that decision reviewed. If enrolled in Original Medicare your appeals rights are stated on the Medicare Summary Notice. If you are in a Medicare Advantage plan, you can file an appeal if your plan does not pay for a service. Contact your plan for information on how to appeal your claim.

**Approved Amount** – The maximum fee that Medicare or other insurers will use in reimbursing a provider for a given service or piece of equipment. The Medicare “approved” charge may be lower than the actual billed amount and is based upon the Medicare Fee Schedule.

**Area Agencies on Aging (AAA)** – Local government agencies which grant or contract with public and private organizations to provide services that help older adults remain independent in their home and community.

**Assessment** – The gathering of information to rate or evaluate your health and needs, such as in a nursing home.

**Asset Protection** – This refers to the protection from Medicaid “spend-down” requirements available under the Medicaid extended coverage feature of the New York State Partnership for Long-Term Care.

**Assignment** – In the Original Medicare Plan, doctors and other providers who accept assignment accept the amount Medicare approves for a particular service or supply as payment in full. (The person with Medicare is still responsible for any deductible and coinsurance amount.) **Not accepting assignment** means the provider does not accept Medicare’s approved amount as payment in full. A provider cannot, however, charge whatever he/she chooses to people with Medicare. Federal and New York State laws limit how much a doctor may charge in excess of Medicare’s approved amount.

**Assisted Living Facility** – A residential living arrangement that provides individual personal care and health services for people requiring assistance with ADLs.

**Automatic Enrollment** – Individuals who are receiving monthly Social Security benefits or Railroad Retirement Board (RRB) benefits prior to attainment of age 65 are automatically enrolled in Medicare Part A and Part B when they attain age 65. Individuals of any age who have been receiving Social Security disability benefits for 24 months are automatically enrolled in Medicare in their 25<sup>th</sup> month.

## B

**Benchmark** – The maximum monthly amount that the Low Income Subsidy, or Extra Help, will pay toward the Medicare Part D monthly premium. Some plans are referred to as benchmark plans due to premiums at or below the benchmark. See Extra Help.

**Beneficiary** – Any person who receives benefits (also referred to as a person with Medicare).

**Benefit Maximum** – The limit a health insurance policy will pay for a certain loss or covered service. The benefit can be expressed either as 1) a length of time (for example, 60 days), or 2) a dollar amount (for example, \$350 for a specific procedure or illness), or 3) a percentage of the Medicare approved amount. The benefits may be paid to the policyholder or to a third party. This may refer to specific illness, time frame, or the life of the policy.

**Benefit Period** – The period of time for which payments for benefits covered by an insurance policy are available. The availability of certain benefits may be limited over a specified time period.

**Medicare Benefit Period** – A Medicare benefit period begins upon entry into a qualified hospital and ends when the patient has been out of a hospital and not receiving Medicare benefits in a skilled nursing facility or rehabilitation services for 60 consecutive days, including the day of discharge.

**Benefit Triggers** – Term used by insurance companies to describe when to pay benefits. Long-term care policies may use functional impairment, limitations in cognitive impairment, medical necessity, and/or a physician’s certification to trigger benefits.

**BIPA** – Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 (BIPA), which includes changes to Medicare coverage, payment mechanism and appeals procedures. Expands Medicaid programs, including the State Children’s Health Insurance Program (SCHIP).

**Board and Care Homes** – Are typically privately operated facilities that provide a room, meals, personal care services, and 24-hour protective oversight.

**C**

**CAHPS (Consumer Assessment of Health Providers and Systems)** – CMS sponsored surveys used to report Medicare beneficiaries' experience with, among other topics, fee-for-service care plans. The results are shared with Medicare beneficiaries and the public.

**Calendar Year** – January 1 through December 31.

**Care Plan** – A written plan for your care. It tells what services you will need to reach and keep your best physical, mental and social well being.

**Case Management** – A process used by a doctor, nurse or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.

**Catastrophic Coverage** – The Medicare Part D prescription drug coverage you will receive until the end of the calendar year after you have spent up to your plan's out-of-pocket limit for that year (\$4,700 in 2012).

**Catastrophic Illness** – A very serious and costly health problem that could be life-threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause financial hardship.

**Centers for Medicare & Medicaid Services (CMS)** – A branch of the Department of Health and Human Services, this federal agency is responsible for administering the Medicare, Medicaid, and Child Health Insurance Programs.

**Certificate of Medical Necessity** – The order, prescription or certificate signed by your Medicare-enrolled provider that explains why you need a particular service (medical necessity). Medicare requires this documentation before it will cover certain Durable Medical Equipment (DME).

**CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)** – Relating to auxiliary medical services for active/retired military and their dependents.

**Charges** – Prices assigned to units of medical service, such as a visit to a physician or a day in the hospital. Charges for services may not be related to the actual costs of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and from institution to institution.

**Chronic** – A lasting, lingering or prolonged illness.

**Claim** – A bill requesting that medical services be paid by Medicare or by some other insurance company.

**Cognitive Impairment** – A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.

**Coinsurance** – A percentage amount that you pay for a medical service after you have paid any deductibles that apply. In Medicare Part B, the percentage of the approved amount (usually 20 percent) that you are responsible for after you have met the annual Part B deductible.

**Community-Based Organization (CBO)** – Community-based service provider.

**Community-Based Services** – Those services that are designed to help older people remain independent and in their own homes; can include senior centers, transportation, delivered meals or congregate meal sites, visiting nurses or home health aides, contingent upon certain specified conditions.

**Confidentiality** – Your right to talk with your health care provider without anyone else finding out what you have discussed.

**Conservatorship** – Legal procedure by which one person, the conservator, is given power over the living arrangements, property and/or finances, of another person, the conservatee. Conservatorships are established with legal safeguards for a person in need.

**Consolidated Omnibus Budget Reconciliation Act (COBRA)** – A federal law that allows workers to remain covered under the employer’s group health plan for a period of time after: the death of a spouse, job loss, having work hours reduced, getting a divorce, or other specified reasons. You have to pay both your share and the employer’s share of the premium.

**Continuing Care Retirement Communities (CCRC)** – Offer housing and a range of health care, social, and other services for substantial initial costs plus monthly fees.

**Contract Supplier** - If you live in, or are visiting certain regions in certain states when you need certain types of Durable Medical Equipment (DME) you must use a contract supplier in order for Medicare to cover your DME. If you do not use a contract supplier Medicare will not pay for your DME.

**Coordination of Benefits (COB)** – A clause in an insurance policy stating the policy will not pay the costs of a covered expense when another insurer pays it or that each insurer will pay part of the costs of the covered service, not to exceed the total actual cost. It is used to prevent the policyholder from receiving duplicate payments for a covered service when he or she is insured by more than one policy.

**Copayment** – A specified dollar amount you pay for a medical service after satisfying any deductible. For example: A Medicare Advantage Plan may have a \$10 copayment for each primary care physician office visit.

**Costs** – Expenses incurred in the provision of services or goods. Charges billed to an individual or third party may not necessarily be the same. Hospitals often charge more for a given service than it actually costs in order to recoup losses incurred from providing other services where costs exceed feasible charges.

**Cost Sharing** – The cost for medical care that you pay yourself, including co-payment, coinsurance, or deductible.

**Coverage Gap (also known as the doughnut hole)** - Once you and your Part D drug plan have spent \$2,930 (in 2012) for covered drugs, you will be in the Coverage Gap. Previously, you had to pay the full cost of your prescription drugs while in the Coverage Gap. The Affordable Care Act, signed into law in March of 2010, provides that in 2012, you receive a 50% discount on covered brand-name prescription medications in the Coverage Gap and a 14% discount on generic drugs in the Coverage Gap.

**Covered Services** – Medicare law permits payment only for services that are “reasonable and necessary for the diagnosis or treatment of an illness or injury.” Therefore, Medicare can pay for services only as long as they are medically necessary.

**CPT** – “Physicians Current Procedural Terminology” according to the CPT 2010 by the American Medical Association. A listing of the descriptive terms and the numeric identifying codes and modifiers for describing and reporting medical services and procedures performed by physicians. These codes are required on claims submitted to Medicare and are shown on the person with Medicare’s MSN.

**Creditable Coverage** – Any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period or prescription drug coverage that is considered to be as good as or better than the Medicare Part D prescription drug coverage benefit.

**Crossover** - A billing arrangement between your Medicare supplemental insurance and Original Medicare whereby your supplemental plan is automatically billed for its share of the cost of your health care services after Medicare claims have been filed

**Custodial Care** – Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. (These may also be referred to as Activities of Daily Living or ADLs.) Medicare generally does not cover custodial care.

## D

**Daily Benefit** – The amount of insurance benefit in dollars a person chooses to buy for long-term care expenses.

**Deductible** – An initial amount of medical expense for which the person with Medicare is responsible before Medicare or an insurance policy will pay.

**Denial** – A decision by Medicare or another insurance that your claim for benefits will not be approved and paid. Common reasons for a denial: the service is not an approved service; the service is not being provided in an appropriate setting; the service is not provided by an approved participating provider; or the service is not medically necessary.

**DHHS** – Department of Health and Human Services (Federal).

**Diagnosis Related Groups (DRGs)** – DRGs are used to determine the amount that Medicare reimburses hospitals for inpatient services. They are part of the Prospective Payment System Categories of illnesses which is divided into over 500 groups, one of which is assigned to a Medicare patient who is being admitted to a hospital. The hospital is reimbursed a fixed amount based on the DRG code for the patient.

**Discharge Plan** – A coordinated plan for post-hospitalization/skilled nursing facility care intended to identify an individual’s need for medical and social services and resources available to help prevent re-hospitalization.

**Disenroll** – To end one’s health coverage with a health plan.

**Dual Eligibles** – People who have both Medicare and Medicaid.

**Duplication of Coverage** – Coverage of the same health services by more than one health insurance policy.

**Durable Medical Equipment (DME)** – Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under Medicare Part B, and the person with Medicare pays 20 percent coinsurance in the Original Medicare plan.

**Durable Medical Equipment Medicare Administrative Contractor (DME MAC)** - A private insurance company that contracts with Medicare to process durable medical equipment (DME) claims. NHIC is the DME MAC for New York State.

**Duration of Benefits** – Time period or maximum amount of dollars for which an insurance policy will pay benefits.

## E

**Effective Date of Coverage** – The starting date of insurance coverage which can be any of the following: 1) Date of the application, 2) Date of the insurance company’s approval, 3) Date the policy is issued.

**Election** – A person’s decision to join or leave the Original Medicare Plan or a Medicare Advantage plan.

**Eligibility/ Medicare Part A** – People with Medicare are eligible for premium-free Medicare Part A (hospital insurance) if: they are 65 or older and receiving Social Security or Railroad Retirement Board benefits, under 65 and have received Social Security disability benefits for 24 months, under 65 and have End-Stage Renal Disease or been diagnosed with Amyotrophic Lateral Sclerosis (ALS), commonly known as Lou Gehrig’s Disease.

**Eligibility/ Medicare Part B** – Automatically eligible for Part B if you are eligible for Part A, also eligible for Part B if not eligible for Part A premium-free, but are age 65 or older and a resident or citizen or lawful alien admitted for permanent residency. You must have lived in the United States continuously during the five years immediately before the month during which you enroll in Part B.

**Elimination Period** – This applies to “hospital indemnity,” long-term care, or other “indemnity” type policies. It is the number of days before any benefit will be paid. (Also known as a deductible or waiting period.)

**Emergency Care** – Care given for a medical emergency when you believe that your health is in serious danger.

**Employer Group Health Plan (EGHP)** – A health plan that gives health coverage to employees, former employees and their families.

**End Stage Renal Disease (ESRD)** – Medical condition in which a person’s kidneys no longer function, requiring the individual to receive dialysis or a kidney transplant to sustain his or her life.

**Enrollment** – Procedure by which eligible persons can sign up for the Medicare program and receive Medicare (Part A and Part B) coverage. It is handled by the Social Security Administration.

**Enrollment Period** – Period during which individuals may enroll in an insurance policy, Medicare Part A and Part B, Part D drug plan or Medicare Advantage plan.

**Episode of Care** – The health care service given during a certain period of time, during a hospital stay or home health service.

**Exception** – A request for a Medicare Part D plan to cover a non-formulary drug or a non-preferred formulary drug at a preferred formulary drug tier.

**Excess Charges** – A limited amount above the Medicare-approved amount charged by doctors and other health care providers who do not accept assignment.

**Exclusion** – An expense or condition that the policy does not cover and toward which it will not pay. Common exclusions may include preexisting conditions, such as heart disease, diabetes, or hypertension. Because of such exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage, either for general conditions or the particular disease. For Medicare supplement insurance, federal law may exclude coverage for pre-existing conditions only for a maximum of six months after coverage begins.

**Explanation of Benefits (EOB)** – An Explanation of Benefits is sent to you to describe what benefits were paid or not paid by your employer-sponsored retiree plan or by your Medigap or other private health insurance. Usually, the reasons for claim denial are listed on the EOB.

**Extra Help** – A Medicare program that helps people with low income and resources pay Medicare Part D Prescription Drug plan costs, such as premiums, deductibles and coinsurance. Also known as the Low-income subsidy (LIS).

## F

**Federally Qualified Health Center (FQHC)** – Health centers that have been approved by the government for a program to give low-cost health care. Medicare pays for some health services in FQHCs that it generally does not cover, such as routine check-ups. FQHCs include community health centers, Tribal health clinics, migrant health services, and health centers for homeless individuals.

**Federal Poverty Level (FPL)** - The federally set level of income that an individual or family can earn below which it is recognized that they cannot afford necessary services. The FPL is used to determine eligibility for Extra Help and the Medicare Savings Programs. The FPL changes every year and varies depending on the number of people in a household.

**Fee-for-Service** – Method of charging whereby a physician or other practitioner bills for each encounter or service rendered. This is the usual method of billing by the majority of physicians.

**Fee Schedule** – A listing of accepted charges or established allowances for specified medical, dental, or other procedures or services. It usually represents either a physician or third party's standard or maximum charges for the listed procedures.

**Fiscal Year (FY)** – The Federal Government's budget (or fiscal) year runs from October 1 to September 30 of the following calendar year.

**Formulary** – A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on the health plan's formulary.

**Fraud** – To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the actual service provided.

**Free Look (Medigap)** – A period of time (usually 30 days) when you can try out a Medigap policy. During this time, if you change your mind about keeping the policy, it can be cancelled.

**Freedom of Information Act** – A law that requires the U.S. Government to give out certain information to the public when it receives a written request. FOIA applies only to records of the Executive Branch of the Federal Government.

**Friendly Visitor** – Volunteers who visit the homebound to sit and talk or sometimes to run errands and shop for them.

## G

**Gag Rule Laws** – Special laws that make sure that health plans let doctors tell their patients complete health care information. This includes information about treatments not covered by the health plan. These laws make it illegal to include “gag” clauses in doctor contracts, which limit a doctor’s ability to give information to patients about treatment choices for a health problem.

**Gaps in Coverage** – The cost or services that are not covered – under the Original Medicare Plan.

**Gatekeeper** – In a managed care plan, this is another name for the primary care doctor. This doctor gives you basic medical services and coordinates proper medical care and referral.

**General Enrollment Period** - January 1 to March 31 of each year in which eligible persons can sign up for Medicare Part B coverage to start in July.

**Grace Period** – A specified period after a premium payment is due on an insurance policy, in which the policyholder may make such payment, and during which the provisions of the policy continue, usually 30 days.

**Grievance** – A complaint about the way your health care plan is giving care. A grievance is not the same as an appeal, which is the way to deal with a complaint about a treatment decision or a service that is not covered. See Medicare Appeal.

**Group Insurance** – A group policy is a written contract between an insurer and a “middle man,” usually an employer or group, which provides benefits to the insured persons holding individual certificates of insurance stating the provisions of the coverage given to each insured individual or family.

**Guaranteed Renewable** – The insurance company agrees to continue insuring the policyholder for as long as the premium is paid. The premiums for the policy cannot be raised for a given policyholder because of the benefits received, but premiums can be raised for all policyholders.

## H

**Health Insurance Portability and Accountability Act (HIPAA)** – Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits. HIPAA also provides rules for disclosure of medical record information.

**Health and Human Services, Department of (HHS)** – An executive department of the federal government that has the ultimate authority for the Medicare and Medicaid programs.

**Health Care Proxy** – This legal document designates and authorizes a person (the “proxy”) to make decisions regarding medical treatment for another only when that person becomes temporarily or permanently incapable of communicating their own care or treatment wishes. The Health Care Proxy document can be revoked at any time.

**Health Insurance Claim Number (HICN)** – The unique alphanumeric Medicare entitlement number assigned to a person with Medicare and which appears on the Medicare card.

**Health Insurance Information, Counseling, and Assistance Program (HIICAP)** – A statewide program developed to enable New York seniors to become educated health care consumers. HIICAP is part of the national SHIP (State Health Insurance Assistance Program).

**Health Insurance Information, Counseling, and Assistance Program (HIICAP) Consortium** – A consortium of private and public organizations that coordinate resources to educate people with Medicare and their families about Medicare and other health insurance.

**Health Maintenance Organization (HMO)** – An organization that, for a prepaid fee, provides a comprehensive range of health maintenance and treatment services (including hospitalization, preventive care, and nursing). Medicare HMOs are a common type of Medicare Advantage plan.

**HMO with a Point of Service Option (HMO-POS)** – A Managed Care Plan, generally less restrictive. A person with this type of plan may use doctors and hospitals outside the plan network for an additional cost.

**Homebound** – Normally unable to leave home. Leaving home takes considerable and taxing effort. You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like a trip to the barber or church service. A doctor must certify this condition.

**Home Health Agency** – A home health agency is a public or private agency that specializes in giving skilled nursing services, home health aides, and other therapeutic services, such as physical therapy, in the home.

**Home Health Care** – Health care services provided in the home on a part time basis for the treatment of an illness or injury. Medicare pays for home care only if the type of care needed is skilled and required on an intermittent basis and is intended to help people recover or improve from an illness, not to provide unskilled services over a long period of time.

**Home Health Prospective Payment System** – A standardized payment system implemented in 2000 by Medicare to help manage health care reimbursement.

**Home Health Resource Group (HHRG)** – HHRGs are used to determine the amount Medicare will reimburse home health agencies for services. The home health agency is paid a set amount based on the HHRG to which a patient is assigned.

**Hospice** – Comprehensive care for people who are terminally ill that includes pain management, counseling, respite care, prescription drugs, inpatient care and outpatient care, and bereavement services for the terminally ill person's family.

**Hospital Indemnity Insurance** – Insurance that pays a fixed cash amount for each day a person is in the hospital up to a certain amount of days. Some policies may have added benefits such as surgical

benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

**Hospital Issued Notice of Noncoverage (HINN)** – Hospitals provide Hospital-Issued Notices of Noncoverage to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is not medically necessary; not delivered in the most appropriate setting; or is custodial in nature.

## I

**Illegal Sales Practices** – Sales techniques used by insurance agents selling health insurance to supplement Medicare (Medigap) in which they mislead older adults into buying unnecessary coverage or paying premiums for no coverage.

**Indemnity Policy** – Type of insurance policy, which pays a fixed amount per day for covered services received, generally a fixed amount per day of covered hospitalization.

**Individual Health Insurance** – An individual policy of insurance is a written contract between an insurance company and an insured person. It is separate from Medicare.

**Individual Insurance Policy** – The individual copy of the master contract that contains a policy number assigned only to the subscriber. That policy number should be used when contacting the insurance company for information.

**Inflation Protection** – A policy option that provides a percentage or dollar amount increase in benefit levels to adjust for inflation or allows the policyholder to purchase additional units of coverage to keep up with inflation

**In-Home Supportive Services (IHSS)** – Personal care services and non-medical services to help functionally impaired persons of all ages, with limited resources, stay at home. Title XX of the Social Security Act authorizes payment to those individuals who qualify for IHSS.

**Initial Coverage Election Period** – The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. You may choose a Medicare Advantage plan during your Initial Coverage Election Period. The plan must accept you unless it has reached its limit in the number of members.

**Initial Coverage Period** – The initial period of Part D insurance coverage after a beneficiary has met any deductible requirement and before expenditures reach the coverage gap (\$2,930 in 2012).

**Initial Enrollment Period (IEP)** – Your IEP starts three months before you first meet all the eligibility requirements for Medicare and continues for seven months. This IEP is the first chance a person has to enroll in Part A or B if they do not get it automatically, without paying a penalty.

**Inpatient** – A person who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health services.

**Institutionalization** – Admission of an individual to an institution, such as a nursing home, where he or she will reside for an extended period of time or indefinitely.

**Insurance Contract** – The master copy of a policy which is submitted to the State Department of Financial Services for approval and sale. It is assigned a form number, which is listed in the bottom left corner of the cover. This number should be used when seeking information from the State Department of Financial Services.

**Insured** – The individual or organization protected in case of loss or covered service under the terms of an insurance policy.

**Insurer** – A company which, for a set premium, agrees to reimburse the insured for a loss covered by an insurance policy.

## L

**Length of Stay** – The time a patient stays in a hospital or other health facility.

**Lifetime Maximum** – The maximum dollar amount that a policy will pay in the policyholder's lifetime.

**Lifetime Reserve Days** – When you are in the hospital for more than 90 days in a single benefit period, Medicare pays for 60 additional reserve days that you can only use once in your lifetime. They are not renewable once you use them.

**Limited Benefits Policy** – Type of insurance policy, which only pays benefits for a specific type of illness or health care services, named in the policy.

**Limiting Charge** – The maximum amount doctors and other health care providers who don't accept assignment can charge for a covered service. The Federal limit is 15 percent over Medicare's approved payment amount. New York State's limit is 5 percent, except for home and office visits, where the limit is 15 percent over Medicare's approved payment amount.

**Lock-In**- Limits your ability to change the way you receive your Medicare health and prescription drug (Part D) coverage to the Annual Coordinated Election Period (ACEP) and Medicare Advantage Disenrollment Period (MADP).

**Long-Term Care (LTC)** – The medical and social care given to individuals who have severe chronic impairments over a long period of time. Long-term care can consist of care in the home, by family members assisted with voluntary or employed help (such as provided by home health care agencies), adult day health care, or care in institutions.

**Long-Term Care Insurance** – A policy designed to help alleviate some of the costs associated with long-term care. Often, benefits are paid in the form of a fixed dollar amount (per day or per visit) for covered LTC expenses and may exclude or limit certain conditions from coverage.

**Loss** – The basis for a claim under an insurance policy. In health insurance, loss refers to expenses incurred resulting from an illness or injury.

**Loss/Benefit Ratio** – The percentage of premiums collected that is returned in benefits to the policyholder by an insurer.

**Low Income Subsidy (LIS)** – See Extra Help.

**M**

**Mammogram** – A special X-ray of the breasts. Medicare covers the cost of a mammogram once a year for women over 40 who are enrolled in Medicare.

**Managed Care Plans** – A health care plan that involves a group of doctors, hospitals and other health care providers who have agreed to provide care to people with Medicare in exchange for a fixed amount of money every month.

**Marketing Fraud** - When Medicare private plans deceive you—through marketing materials or through a person misrepresenting the plan—about what the plan offers and how much it costs.

**Medicaid** – Federally assisted, state-administered program to finance health care services for low-income persons of all ages.

**Medical Underwriting** – The process that an insurance company uses to decide whether or not to take your application for insurance, whether or not to add a waiting period for preexisting conditions and how much to charge you for that insurance.

**Medically Necessary** – Procedures, services or equipment that meet medical standards and are necessary for the diagnosis and treatment of a medical condition. Medical necessity must be established (via diagnostic and/or other information presented on the claim under consideration) before the insurer will make payment.

**Medicare** – Title XVIII of the Social Security Act, federal health insurance program for people 65 and older and some under 65 who are disabled. Medicare has two parts. Part A is Hospital Insurance and primarily provides coverage for inpatient care. Part B is Medical Insurance and provides limited coverage for physician services and supplies for the diagnosis and treatment of illness or injury. You can receive Medicare health insurance coverage directly through the federal government (see Original Medicare) or administered through a private company (see Medicare Advantage).

**Medicare Advantage (also known as Part C or health plan)**– Medicare program developed as a result of the Balanced Budget Act of 1997, which provides people with Medicare with many different health insurance options. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like dental care, eyeglasses or hearing aids.

**Medicare Appeal** – Procedure in which a person with Medicare who disagrees with the denial of payment for a claim by Medicare can challenge the decision made.

**Medicare Administrative Contractor (MAC)** – A private company that contracts with CMS to pay both Medicare Part A and Part B bills. The MAC replaces Medicare Part A intermediaries and Part B carriers.

**Medicare Advantage Disenrollment Period (MADP)** – the first 45 days of each year (January 1 through February 14) when you can leave your Medicare Advantage Plan and change to Original Medicare with or without also selecting a standalone Medicare drug plan. You cannot make changes during this time if you have Original Medicare. You cannot switch from one Medicare Advantage Plan to another during this time.

**Medicare as Secondary Payer (MSP)** – Situations, defined by law, in which Medicare payment may be made only after another source has either paid or denied payment of medical items and/or services.

**Medicare Medical Savings Account (MSA) Plan** – Combines a high deductible Medicare Advantage plan with a Medical Savings Account for medical expenses.

**Medicare Part A (Hospital Insurance)** – Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

**Medicare Part B (Medical Insurance)** – Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services.

**Medicare Part D (Medicare Prescription Drug Coverage)** – Coverage for prescription drugs which is available through private stand-alone plans for people on Original Medicare or through Medicare Advantage plans for their members.

**Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)** – the federal law directing Medicare to provide Part D prescription drug coverage and other changes.

**Medicare Savings Programs (MSP) Also known as “Medicare Buy-In” programs** - Help pay your Medicare premiums and sometimes also coinsurance and deductibles. There are three main Medicare Savings Programs, with different eligibility limits: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) program. The Qualified Disabled Working Individual (QDWI) program is a less common MSP for people who are under 65, have a disabling impairment, and continue to work.

**Medicare Secondary Payer** – The insurance company that pays second on a claim for medical care.

**Medicare Select** – A type of Medigap policy that may require you to use doctors and hospitals within its network to be eligible for benefits.

**Medicare Summary Notice (MSN)** – A notice mailed to beneficiaries from Original Medicare that lists services received from doctors, hospitals or other health care providers. It details what the provider billed Medicare, Medicare's approved amount for the service, the amount Medicare paid, and what you have to pay. An MSN is not a bill.

**Medigap/Medicare Supplement** – Type of insurance policy with coverage specifically designed to fill the major benefit gaps in Medicare Part A and Part B (deductibles and coinsurance). Medigap policies only work with the Original Medicare Plan.

## N

**National Association of Insurance Commissioners (NAIC)** – The organization that prepares model provisions and guidelines for insurance companies and state legislatures.

**National Committee for Quality Assurance (NCQA)** – A non-profit organization that accredits and measures the quality of care in Medicare health plans. NCQA does this by using the Health Employer Data and Information Set (HEDIS) data reporting system.

**Neglect** – When caretakers do not give a person they care for the goods or services needed to avoid harm or illness.

**Network** – A group of doctors, hospitals, pharmacies and other health care experts hired by a health plan to take care of its members.

**Noncovered** – Health care costs that Medicare does not cover at all.

**Nonforfeiture Benefits** – A policy feature that returns at least part of the premiums if the policyholder cancels or lets the policy lapse. For example, the "Reduced Paid-Up Benefit" provides reduced benefits for the original term of the policy, and the "Shortened Benefit Period" provides full benefits for a reduced period of time.

**Non-participating Facility** – Health care facility that does not participate in the Medicare program and usually does not accept Medicare payment for services received in the facility.

**Non-Participating Provider** - In Original Medicare, this is a provider that does not always accept assignment. Non-participating providers may charge up to 15 percent of Medicare's approved amount for the service or item on top of the Medicare coinsurance. In addition, the provider can request full payment up front and will then submit the bill to Medicare for reimbursement.

**Notice of Discharge and Medicare Appeal Rights (NODMAR)** – A written discharge notice given to Medicare Advantage plan enrollees that states if a person with Medicare chooses to stay in the hospital, he/she will be responsible for services provided beginning on the third day after the notice has been received; the notice also explains the Medicare appeal process.

**Nursing Home** – Also referred to as a long-term care facility or skilled nursing facility. A residence for persons who need some level of medical assistance and/or assistance with activities of daily living. If certain health criteria are met, Medicare covers a limited stay in a Medicare-certified skilled nursing facility for rehabilitation therapies. Not all nursing homes are Medicare approved/certified facilities.

**Nursing Home Policy** – Type of limited health insurance policy, which generally pays indemnity benefits for medically necessary stays in nursing facilities (sometimes referred to as Long-Term Care policies).

## O

**Observation Status** - a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients (Medicare Part A applies) or if they are to be treated on an outpatient basis (Medicare Part B applies).

**Occupational Therapy** – Activities designed to improve the useful functioning of physically and/or mentally disabled persons.

**Ombudsman** – A “citizens’ representative” who protects a person’s rights through advocacy, providing information and encouraging institutions or agencies to respect citizens’ rights.

**Opt-Out** - Doctors can “opt-out” of Medicare by notifying the Medicare Administrative Contractor that they will not accept Medicare payments and informing their patients in writing before providing services. Doctors who have “opted-out” can charge as much as they want, and their patients have to pay the entire bill themselves. The only time a doctor who has opted out can receive payment from Medicare is when the doctor provides a patient emergency or urgent care services and the patient does not have a contract with that doctor. If the doctor did not provide a written contract before the patient received the services, the patient is not liable for payment.

**Original Medicare Plan (Traditional Medicare)** – the pay-per-visit federal health insurance program created in 1965 that provides coverage for medically necessary services from any doctor, hospital, or other health care provider who accepts Medicare regardless of location. Persons with Original Medicare share costs by paying deductibles and coinsurances. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance)

**Out-of-Pocket Costs** – Health care costs that you must pay because Medicare or other health insurance does not cover them.

**Outlier Case** – Outlier cases are atypical cases which involve longer hospital stays or higher treatment costs.

**Outpatient** – A patient who receives care outside of a facility or at a hospital or other health facility without being admitted to the facility.

**Outpatient Hospital Services** – Medicare or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay. This includes: blood transfusions, certain drugs, hospital billed laboratory tests, mental health care, medical supplies such as splints and casts, emergency services or outpatient clinics, including same day surgery and X-rays or other radiation services.

**Outpatient Prospective Payment System (OPPS)** – The way that Medicare pays for most outpatient services at hospitals or community mental health centers.

**Over-the-Counter Drug** - A drug that you can buy without a prescription, at your local pharmacy or drug store. These drugs are not covered by the Medicare Part D Prescription Drug Plan.

## P

**Participating Facility** – Health care facility, which participates in the Medicare program and accepts Medicare payment for services received in the facility.

**Participating Physician/Supplier Agreement** – An agreement, by an individual physician or supplier, to always accept assignment on claims for Medicare-covered items and services.

**Patient Assistant Program** - A program offered by a pharmaceutical company or healthcare provider that offers lower-cost or free prescriptions or services to people with low incomes.

**Patient Representative** – A member of the hospital staff who serves as a link between patient, family, physicians and other hospital staff. The representative should be available to answer questions about hospital procedures, help with special needs or concerns and help solve problems (i.e., explaining hospital notices, etc.). There is no charge for services provided by the patient representative.

**Period of Care (Hospice)** – A set period of time that hospice services are provided. Additional periods of care are possible if the patient is evaluated and still found to be hospice appropriate. Hospice has unlimited periods of care.

**Personal Care** - Assistance with bathing, cooking, dressing, eating, grooming, or personal hygiene. Providers of personal care (home health aides) are not required to undergo medical training. Medicare only covers personal care if you are homebound and receiving skilled care.

**Personal Comfort Items** – For inpatients in a hospital, such items as a television, telephone, etc.

**Physical Therapy** – Services provided by specially trained and licensed physical therapists in order to relieve pain, restore maximum function, and prevent disability, injury or loss of body part.

**Physician Assistant (PA)** – A person who has two or more years of advanced training and has passed a special exam. They work with a doctor and can do some of the job that a doctor can do.

**Physician Payment Reform** – Replacement of Medicare’s “Reasonable Charge” payment method with a Relative Value payment system. Restrictions on fees will decrease the difference between Medicare approved amounts and the actual charges.

**Point of Service Option (POS)** – Gives managed care plan members the right to partial coverage for certain services they get outside the managed care plan network.

**Power of Attorney** – A legal document which gives a person (usually a spouse, other relative, or friend) the power to act on behalf of another. The person giving the power of attorney must be competent, and does not lose the legal right to act on his own behalf.

**Pre-Authorization** – Also called “pre-approval.” An approval that must be asked for from a managed care plan or primary care doctor for care, treatment, or other medical services needed.

**Pre-existing Condition** – Health conditions or problems that were identified and treated before health insurance was purchased. The definition and waiting period before these conditions are covered varies from policy to policy. However, there is a maximum six-month waiting period for Medigap policies and treatment must have been received in the preceding six months for the condition to be considered “pre-existing.”

**Preferred Provider Organization (PPO)** – Type of Medicare Advantage plan under which you can get coverage for providers both in **and** out of network; although, it usually costs the member more to see an out-of-network provider.

**Premium** – Dollar amount paid periodically (monthly, quarterly, or yearly) by an insured person or policyholder in exchange for a designated amount of insurance coverage.

**Premium Penalty** - An amount that you must pay in addition to the regular monthly premium for late enrollment in Part B or Part D. The Part B penalty is an additional 10 percent of the premium for each year you delay enrollment that you did not have coverage from a current employer. Part D imposes a premium penalty of 1 percent for every month of delayed enrollment without creditable drug coverage.

**Prescription Drug Plan (PDP)** – Stand-alone drug plan offered by private companies (contracted with Medicare) available to beneficiaries on Original Medicare or on a Medicare Private Fee-for-Service plan without Part D.

**Preventive Services** – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, colorectal cancer screenings, yearly mammograms, PSA testing and flu shots).

**Prior Authorization** - Also called pre-authorization or pre-approval. Approval may be required before a medical service is provided under a Medicare Advantage plan or a prescription drug is covered under a Part D plan. For a service or medication to be covered a provider must get special permission from the plan. When prior authorization is required, an insurer can deny coverage for services already provided or for proposed services that are deemed not to be medically necessary.

**Primary Care Physician (PCP)** – A doctor who is trained to give you basic care. This includes being the first one to check on health problems and coordinating your preventive health care with other doctors, specialists and therapists. In many Medicare managed care plans, you must see your primary care doctor before you can see any other health care professional.

**Primary Payer** – The insurance company that pays first on a claim. This could be Medicare or other insurance.

**Private Fee-For-Service Plan (PFFS)** – a type of managed care plan that allows a Medicare beneficiary to receive services from any doctor or hospital regardless of location as long as that provider accepts the plan's terms and conditions. The insurance plan, rather than the Medicare program, determines how much the person with Medicare pays for services.

**Prospective Payment System (PPS)** – A standardized payment system to help manage health care reimbursement whereby the incentive for hospitals to deliver unnecessary care is eliminated. Under PPS, hospitals are paid fixed amounts based on the principal diagnosis for each hospital stay. In some cases the Medicare payment will be more than the actual cost of providing services for that stay; in other cases, the payment will be less than the hospital's actual cost. In special cases, the hospital may receive additional payment for unusually high costs. Also see "Outlier Cases."

**Provider** – A doctor, hospital, other health care professional or health care facility.

**Provider Sponsored Organization (PSO)** – A Medicare Advantage plan that is operated by a group of doctors and hospitals that form a network of providers within which a person with the plan must stay to receive coverage. This type of plan is not available in New York State.

## Q

**Qualified Disabled Working Individual (QDWI)** - A less common Medicare Savings Program (MSP) administered by each state's Medicaid program. It pays the Medicare Part A premium for people who are under 65, have a disabling impairment, continue to work, and are not otherwise eligible for Medicaid.

**Qualified Medicare Beneficiaries (QMB)** – A Medicaid program that pays the Medicare Part A premium, Part B premium, and Medicare deductibles and coinsurance amounts for services provided by Medicare providers for individuals who have Medicare Part A, and a low monthly income.

**Qualifying Individual (QI)** – A Medicaid program that pays the Medicare Part B premium for individuals who have Medicare Part A, and a low monthly income, but who are not otherwise eligible for Medicaid.

**Quality Improvement Organization (QIO)** – Groups of practicing doctors and other health care professionals paid by the federal government to monitor the care given to Medicare patients. They are responsible for reviewing complaints from people with Medicare about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; Medicare Advantage plans and ambulatory surgical centers.

**Quantity Limit** - A restriction used by private health plans and Medicare Part D plans that limit coverage of a particular drug to a specific quantity (such as 30 pills a month).

**R**

**Railroad Retirement** – Persons who worked for a railroad company are entitled to their benefits at retirement (includes Medicare), similar to Social Security benefits.

**Reasonable and Necessary Care** – The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

**Reconsideration** – The second level in the Medicare Part A and Part B appeals process.

**Redetermination** - The first level in the Medicare Part A and Part B appeals process that occurs when a person with Medicare receives a Medicare Summary Notice (MSN) with a denial of coverage and appeals that decision.

**Referral** – A written authorization from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed care plans, this is a necessary step.

**Renewable at Company Option** – A right reserved by the insurance company to stop insuring an individual, but the company cannot stop paying benefits provided by the policy in the midst of an illness.

**Respite Care** – Short-term care given to a hospice patient by another caregiver, so that the usual caregiver can rest. A volunteer, an institution, or an adult day care center may provide the care.

**Retiree Insurance** - Health insurance provided by employers to former employees who have retired. Retiree insurance is always secondary to Medicare.

**Retroactive Disenrollment** - A way to discontinue enrollment in a Medicare Advantage or Medicare Part D Prescription Drug Plan that you mistakenly joined or joined due to marketing fraud, effective back to the date you joined. A person with Medicare will be disenrolled from the Medicare private health or drug plan as if they had never joined it.

**Rider** – A legal document which modifies the protection of an insurance policy, either extending or decreasing its benefits, or which adds or excludes certain conditions from the policy's coverage.

**S**

**Second Opinion** – When another doctor gives his or her view about a patient's diagnosis and treatment.

**Secondary Payer** – A payer of health benefits whose payments cannot be made until another primary party has processed the claim and issued a claim determination.

**Self-pay** – Consumers pay for all of their own health care costs.

**Senior Medicare Patrol (SMP)** – A federally funded nation-wide, long-term initiative to fight fraud, waste, error and abuse in Medicare and Medicaid.

**Service Area** – The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll a member if they move out of the plan's service area.

**Service Benefits** – Type of benefits in a health insurance policy, which pays the costs of the services, covered by the policy rather than a fixed dollar amount per day to cover any services received.

**Skilled Nursing Care** – Care that can only be provided by or under the supervision of licensed nursing personnel or professional therapists under the general direction of a physician.

**Skilled Nursing Facility (SNF)** – A Medicare approved facility which is staffed and equipped to furnish skilled nursing care and skilled rehabilitation services for which Medicare pays benefits.

**Specified Low-Income Medicare Beneficiary (SLMB)** – A Medicaid program that pays the Medicare Part B premium for individuals who have Medicare Part A and a low monthly income.

**Social Security Administration (SSA)** – The federal agency responsible for determining Medicare eligibility and handling the Medicare enrollment process.

**Special Enrollment Period (SEP)** – A period of time when a person with Medicare can enroll in or switch their Part D plan outside of the Annual Coordinated Election Period (October 15 – December 7) due to special circumstances. The term is also used in the context of enrolling in Medicare Part B following the end of a beneficiary's coverage through their own or their spouse's current employment.

**Special Needs Plan (SNP)** – Type of Medicare Advantage plan that provides specialized care for specific groups of people with Medicare, such as those with both Medicare and Medicaid, institutionalized beneficiaries or with certain chronic conditions.

**Specific Disease Policy** – Type of limited health insurance policy which only covers the expenses incurred for the specific disease named in the policy. The most common type is cancer insurance.

**Speech Therapy** – The study, examination, and treatment of defects and diseases of the voice, speech, spoken and written language.

**Spenddown** – When individuals deplete their income and assets and thereby meet Medicaid financial eligibility requirement.

**Spousal Impoverishment Protection Law** – Law which allows the at-home spouse of a Medicaid-eligible nursing home resident to keep a minimum amount of joint income and assets.

**State Health Insurance Assistance Program (SHIP)** – Federally-funded program to train volunteers to provide counseling on the insurance needs of senior citizens.

**Step Therapy** – A type of prior authorization in which a Medicare Part D plan requires a member to try less expensive drugs for the same condition before they will pay for a particular formulary drug.

**Social Security Disability Insurance (SSDI)** - Monthly benefits provided through the [Social Security Administration](#) for people who lose their ability to work because of a severe medical impairment ([disability](#)). People who receive SSDI for 24 months are eligible for [Medicare](#).

**Supplemental Security Income (SSI)** – A federal program that pays monthly checks to people in need who are 65 years or older and to people at any age who are blind and disabled and in need. The purpose of the program is to provide sufficient resources so that anyone who is blind or disabled can have a basic monthly income. Eligibility is based on income and assets.

**Suppliers** – Persons or organizations, other than physicians or health care facilities, that furnishes durable medical equipment, prosthetics, orthotics or medical supplies.

**Swing Beds** – A unit of beds in a hospital designated for the Medicare program for both traditional hospital acute care and long term care and rehabilitation.

## T

**Tax-Qualified Long-Term Care Insurance Policy** – A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

**Therapy Caps** - Limits on the amount of physical therapy, occupational therapy and speech/language pathology that Medicare will cover in a given year.

**Transition Policy or Temporary First-Fill** - Allows new members of Medicare private drug plans (Part D) to get temporary coverage of drugs they were taking before they joined if those medications are not covered by their new plan.

**Third-Party Liability** – A party other than a person with Medicare who is responsible for payment of part or all of a specific Medicare claim. Medicare Supplement Insurance (Medigap) coverage is one example.

**Third-Party Notice** – A benefit that lets you name someone who the insurance company would notify if your coverage is about to end due to lack of premium payment. This can be a relative, friend, or professional such as a lawyer or accountant.

**Tiers** – Different levels of drug coverage within the same Medicare Part D plan. Plans may have tiers for generic, preferred brand name, non-preferred brand name and specialty drugs.

**Title XVIII** – That portion of the Social Security Act, which clearly defines the provisions of Medicare.

**Title XIX** – That portion of the Social Security Act that clearly defines the provisions of Medicaid.

**TRICARE** – TRICARE is the health care program for members of the military, eligible dependents and military retirees.

**Twisting** – The insurance sales practice of replacing an existing health insurance policy with a new one from a different company in order to receive the high first year sales commission.

## U

**Unassigned Claim** – A claim on which the doctor or supplier refuses to accept Medicare's approved charge as payment in full.

**Underwriting** – The process by which an insurer establishes and assumes risks according to insurability.

**Urgent Care** – Immediate medical attention for a sudden illness or injury that is not life threatening.

**Usual, Reasonable, Customary Charges** – In “insurance language,” this is the maximum amount a company will pay on a claim as determined by their guidelines. (Similar to Medicare’s “approved charge.”)

**Utilization Review Committee** – Committee in a health care facility which evaluates the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. This includes a current and retroactive review of the appropriateness of admissions; services ordered and provided, length of stay, and discharge practices.

## V

**Viatical Settlement** – Viatical settlement companies make lump sum payments to life insurance policy holders with catastrophic or life-threatening illnesses in return for having the policy’s death benefit assigned to that company.

**Visit** – An encounter between a patient and a health care professional which requires either the patient to travel from his home to the professional’s usual place of practice (an office visit), or for the doctor or other health care provider to see the patient in the hospital, skilled nursing facility, or in the patient’s home. Doctors’ services can be covered in any of these settings under Medicare.

## W

**Waiting Period** – The period of time that must pass after becoming insured before the policy will begin to pay benefits for a preexisting condition.

## ACROYNMS

## A

AACR	American Association for Cancer Research
AAHA	American Association of Homes for the Aging
AAHP -	American Association of Health Plans
AAHSA	American Association of Homes & Services for the Aging
AAKP	American Association of Kidney Patients
AARP	American Association of Retired Persons
ABD	Aged, Blind & Disabled
ABH	Association of Behavioral Healthcare
ABN	Advance Beneficiary Notice of Noncoverage
ABR	American Board of Radiology
ABS	Annual Beneficiary Summary
AC	Actual Charge
ACA	Affordable Care Act (2010)
ACA	Amputee Coalition of America
ACF	Administration for Children & Families
ACR	Adjusted Community (Contract) Rate
ACRP	Adjusted Community Rate Proposal
ACS	American Cancer Society
ACSI	American Customer Satisfaction Index
ACTG	AIDS Clinical Trials Group
ACYF	Administration on Children, Youth & Families
ADA	Americans with Disabilities Act (of 1990)
ADC	Adult Day Care
ADL	Activities of Daily Living
ADMS	Alcohol, Drug Abuse & Mental Health Services
ADP	(Medicaid) Alternative Disposition Plan
ADP	Advance Planning Document
ADT	Admission/Discharge Transfer
AEP	Annual Coordinated Election Period
AFDC	Aid to Families with Dependand Children (Title IV of the SS Act)
AHA -	American Heart Association
AHA	American Hospital Association

AHRQ	Agency for Healthcare Research & Quality
AKF	American Kidney Fund
ALJ	Administrative Law Judge
ALOS	Average Length of Stay
ALS	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
ALS	Advanced Life Support
ALT	Average Length of Treatment
AMA	American Medical Association
AMA	Against Medical Advice
ANA	Administration for Native Americans
ANOC	Annual Notice of Change (Medicare Part D)
AOA	Administration on Aging
APD	Advanced Planning Documents
APTD	Aid to the Permanently & Totally Disabled
AQL	Acceptable Quality Level
ARA	Alliance for Retired Americans
ARC	American Red Cross
ARRA	American Recovery and Reinvestment Act (of 2009)
ASA	American Society on Aging
AWV	Annual Wellness Visit

**B**

BAE	Best Available Evidence (Part D)
BBA	Balanced Budget Act (of 1997)
BBRA	Balanced Budget Refinement Act of 1999 (PL 106113)
BC/BS	Blue Cross/Blue Shield
BCB	Beneficiary Confidentiality Board
BCBSA	Blue Cross/Blue Shield Association
BCF	Benefit Correction Form
BMI	Body Mass Index
BP	Benefit Period

**C**

CA	Cancer
CAH	Critical Access Hospital CAHPS - Consumer Assessments of Health Plans Survey
CASPER	Certification and Survey Provider Enhanced Reporting

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CBO	Community Based Organization
CCRC	Continuing Care Retirement Community
CDC	Center for Disease Control
CHIP	Child Health Insurance Program
CLT	Certified Lab Technician
CMS	Centers for Medicare & Medicaid Services
CN	Claim Number (also C/N)
COA	Change of Address
COB	Coordination of Benefits
COBA	Coordination of Benefits Agreement
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act (of 1985)
COLA	Cost of Living Adjustment
CPAP	Continuous Positive Airway Pressure
CPD	Competitive Pricing Demonstration
CVD	Cardiovascular Disease
<b>D</b>	
DC	Discharge
DD	Developmental Disabilities
DFS	Department of Financial Services (formerly NYS Insurance Dept)
DHHS	Department of Health & Human Services
DI	Disability Insurance
DIS	Disabled (Beneficiary)
DME	Durable Medical Equipment
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DOB	Date of Birth
DOEH	Date of Entitlement to Hospital Insurance (Medicare Part A)
DOES	Date of Entitlement to Supplementary Medical Insurance (Part B)
DOL	Department of Labor
DVA	Department of Veterans Affairs (see VA)
DWA	Disabled Working Aged
DWB	Disabled Widow's Benefits
DWI	Disabled & Working Individual (see QDWI)
DX	Diagnosis

**E**

EGHP	Employer Group Health Plan
EH	Extra Help (Medicare Part D)
EMTALA	Emergency Medical Treatment and Active Labor Act
EOB	Explanation of Benefits
EPIC	Elderly Pharmaceutical Insurance Coverage Program (NYS)
ESRD	End-Stage Renal Disease

**F**

F&A	Fraud & Abuse
FAQ	Frequently Asked Question
FBR	Federal Benefit Rate
FDA	Food & Drug Administration
FEHB	Federal Employees Health Benefits (Program)
FFS	Fee for Service
FHP	Family Health Plus
FOIA	Freedom of Information Act
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FRA	Full Retirement Age
FSA	Flexible Spending Accounts

**G**

GEP	General Enrollment Period (Medicare Part B)
GHP	Group Health Plan
GSA	Gerontological Society of America

**H**

HCBWP	Home & Community Based Waiver Program
HEDIS	Healthplan Employer Data Information Sets
HHQI	Home Health Quality Initiative
HHS	(Department of) Health & Human Services (also DHHS)
HIB	Hospital Insurance Benefits (Part A)
HIICAP	Health Insurance Information, Counseling & Assistance Program
HIPAA	Health Insurance Portability & Accountability Act (of 1996)
HMO	Health Maintenance Organization

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HRA	Health Reimbursement Accounts
HRSA	Health Resources and Services Administration
HSA	Health Savings Account
<b>I</b>	
IADL	Instrumental Activities of Daily Living
ICEP	Initial Coverage Election Period (Medicare Advantage)
IEP	Initial Enrollment Period
IEQ	Initial Enrollment Questionnaire
IPPE	Initial Preventive Physical Exam
IRE	Independent Review Entity
<b>J</b>	
JCAHO	Joint Commission for Accreditation of Health Organizations
<b>L</b>	
LCD	Local Coverage Determination
LEP	Late Enrollment Penalty (Medicare Part D)
LIS	Low Income Subsidy (AKA Extra Help) (Medicare Part D)
LPR	Lawful Permanent Resident (“Green Card” Holder)
LRD	Lifetime Reserve Days
LTC	Long Term Care
LTCF	Long Term Care Facility
LTCI	Long Term Care Insurance
<b>M</b>	
MA	Medicare Advantage
MAC	Medicare Appeals Council
MAC	Medicare Administrative Contractor
MADP	Medicare Advantage Disenrollment Period
MAPD	Medicare Advantage Prescription Drug (Plan)
MBN	Medicare Benefit Notice
MCCAP	Managed Care Consumer Assistance Program
MCO	Managed Care Organization
MEDIC	Medicare Prescription Drug Integrity Contractor
MI	Medical Insurance (Part B or SMI)
MMA	Medicare Modernization Act

MMAAP	(AARP) Medicare/Medicaid Assistance Program
MMDDCCYY	Two-digit Month/Day/Century Year (i.e., 02/26/2001)
MMDDYY	MonthMonth/DayDay/YearYear
MOOP	Maximum Out of Pocket (Medicare Advantage)
MSA	Medical Savings Accounts
MSN	Medicare Summary Notice
MSP	Medicare Savings Programs
MSP	Medicare Secondary Payer

**N**

NAIC	National Association of Insurance Commissioners
NASI	National Academy of Social Insurance
NCD	National Coverage Determination
NCI	National Cancer Institute
NCOA	National Change of Address (SSA & USPS)
NCOA	National Council on Aging
NCQA	National Committee for Quality Assurance
NCQHC	National Committee for Quality Health Care
NGS	National Government Services
NIA	National Institute on Aging
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NKF	National Kidney Foundation
NMEP	National Medicare Education Program
NYP\$	New York Prescription Saver (Discount Card)
NYS DoH	New York State Department of Health
NYSOFA	New York State Office for the Aging
NYSPLTC	New York State Partnership for Long-Term Care

**O**

OAC	OASIS Automation Coordinator
OBQM	Outcome Based Quality Monitoring
OEC	OASIS Educational Coordinator
OGC	(HHS) Office of the General Council
OIG	Office of the Inspector General
OMRDD	Office of Mental Retardation and Developmental Disabilities

OOP	Out Of Pocket
OP	Outpatient
OP	Overpayment
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OT	Occupational Therapy
OTC	Over the Counter

**P**

PA	Prior Authorization
PA	Public Assistance
PACE	Program for All Inclusive Care for the Elderly
PDP	Prescription Drug Plan
PEBS	Personal Earnings & Benefit (PEBES) Statement
PFFS	Private Fee-For-Service
PO	Post Office
PPO	Preferred Provider Organization
PT	Physical Therapy

**Q**

Q&A	Questions & Answers
QDWI	Qualified Disabled & Working Individual
QI	Qualifying Individual
QIES	Quality Improvement Evaluation System
QIO	Quality Improvement Organization
QL	Quantity Limits (Medicare Part D)
QMB	Qualified Medicare Beneficiary

**R**

RDF	Renal Dialysis Facility
RFA	Reason for Assessment
RNHCI	Religious Non-Medical Health Care Institution
ROC	Resumption of Care
RRB	Railroad Retirement Board

**S**

S&C	Survey and Certification
SCHIP	State Child Health Insurance Program
SEP	Special Enrollment Period
SGA	Substantial Gainful Activity
SHI	Supplemental Health Insurance
SHIP	State Health Insurance Assistance Program (NY State HIICAP)
SLMB	Specified Low-income Medicare Beneficiary
SMP	Senior Medicare Patrol (Fraud and Abuse)
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SNT	Supplemental Needs Trust
SOB	Statement of Benefits
SPAP	State Pharmaceutical Assistance Program (NY State EPIC)
SS	Social Security
SSA	Social Security Act
SSA	Social Security Administration
SSA	State Survey Agency
SSANY	State Society on Aging of New York
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSN	Social Security Number
ST	Speech Therapy
ST	Step Therapy (Medicare Part D)

**T**

TBD	To Be Determined
TDD	Telecommunications Device for the Deaf
TEP	Technical Experts Panel
TITLE I	Grants to States for old age & medical assistance for the aged
TITLE II	Federal old age, survivors & disability insurance benefits (OASDI)
TITLE IV	Grants to States for aid & services to needy families with children (AFDC)
TITLE X	Grants to States for aid to the blind (AB)
TITLE XIV	Grants to States for aid to the permanently & totally disabled (DI)
TITLE XIX	Grants to States for medical assistance programs (MAA) (Medicaid)

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TITLE XVI	Grants to States for aid to the aged, blind and disabled (ABD) & Supplemental Security Income (SSI)
TITLE XVIII	Health Insurance (Medicare)
TITLE XX	State operated home health care entitlement program
TITLE XXI	State Child Health Programs
TPN	Total Parenteral Nutrition
TTY	Text Telephones
TWWIA	Ticket to Work & Work Incentives Act of 1999
<b>U</b>	
UMW	United Mine Workers
UPS	United Parcel Service
USPS	United States Postal Service
<b>V</b>	
VA	Veterans Administration
<b>X</b>	
XIV	Title 14 Grants to States for Aid to the Permanently & Totally Disabled
XIX	Title 19 Grants to States for Medical Assistance Programs (MAA)
XIXED	Title 19 Entitlement Date
XVI	Title 16 Grants to States for Aid to the Aged, Blind or Disabled or Aid & Medical Assistance for the
XVIII	Title 18 Medicare
XX	Title 20 State operated home health care entitlement program
XXI	Title 21 State Child Health Program
<b>Y</b>	
Y2K	Year 2000
YOB	Year of Birth
YR	Year
YTD	Year-To-Date
YYYY	Year (i.e., mmddyyyy)
<b>Z</b>	
ZIP+4	Nine-digit ZIP Code Plan