

# Glossary of Terms and Acronyms

## Glossary of Terms

**Access:** Potential and actual entry into the health care system.

**Ambulatory services:** Medical services provided to patients who are not hospitalized.

**Ancillary services or technology:** Medical services or technology used directly to support basic clinical services, including diagnostic radiology, radiation therapy, clinical laboratory, and other special services.

**Approved charge (Medicare):** An individual charge determination made by a Medicare carrier on a covered Part B medical service or supply. In the absence of unusual medical circumstances, it is the lowest of: 1) the physician's or supplier's customary charge for that service, 2) the prevailing charge for similar service in the locality (adjusted if necessary by the Medicare Economic Index), 3) the actual charge made by the physician or supplier, and 4) the carrier's private business charge for a comparable service. Also called "allowed charge" or "reasonable charge."

**Bladder:** See *urinary bladder*.

**Cavitation payment method:** A method of paying for medical care by a prospective per capita payment that is independent of the number of services received.

**Carrier (Medicare):** Organizations, typically Blue Shield plans or commercial insurance firms, under contract to the Health Care Financing Administration for administering Part B of the Medicare program. Their tasks include computing reasonable charges for physician services, making actual payments, determining whether claims are for covered services, denying claims for noncovered services, and denying claims for unnecessary use of services.

**Case mix:** The relative frequency of admissions of various types of patients, reflecting different needs for hospital resources. There are many ways of measuring case mix, some based on patients' diagnoses or the severity of their illnesses, some on the utilization of services, and some on the characteristics of the hospital or area in which it is located.

**Catheter:** A tubular instrument, often with specially designed tips, used for discharging fluids or for distending a passage. A catheter is frequently placed in the urinary tract of patients with stones to aid in the passage and discharge of urine, stone fragments, or small whole stones.

**Certificate-of-need (CON):** A regulatory planning mechanism required by the National Health Planning Resources Development Act of 1974 (Public Law 93-641) to control expenditures for and distribution of expensive medical care facilities and equipment. CON applications by institutions are reviewed by local health systems agencies, who recommend approval or disapproval; they are denied or approved by State health planning and development agencies.

**Coinsurance:** That percentage of covered hospital and medical expenses, after subtraction of any deductible, for which an insured person is responsible. Under Medicare Part B, after the annual deductible has been met, Medicare will generally pay 80 percent of approved charges for covered services and supplies; the remaining 20 percent is the coinsurance, which the beneficiary pays.

**Colic:** Severe pain.

**Coverage (Medicare):** In the Medicare program, coverage refers to the benefits available to eligible beneficiaries and can be distinguished from payment, which refers to the amount and methods of payment for covered services.

## Current Procedure Terminology, Fourth Revision

**(CPT-4) Coding:** A taxonomy of procedures performed by physicians that is used for recording and billing for service rendered. This taxonomy has been incorporated in the HCFA Common Procedure Coding system, which all Medicare carriers are now required to use.

**Customary charge (Medicare):** In the absence of unusual medical circumstances, the maximum amount that a Medicare carrier will approve for payment for a particular service provided by a particular physician practice.

**Customary, prevailing, and reasonable charges:** The method used by Medicare carriers to determine the approved charge (see definition) for a particular Part B service from a particular physician or supplier.

**Deductible:** An initial expense of a specified amount of approved charges for covered services within a given time period (e.g., \$75 per year) payable by an insured before the insurer assumes liability for any additional costs of covered services. The Medicare Part B deductible is the portion of approved charges (for covered services each calendar year) for which a beneficiary is responsible before Medicare assumes liability.

**Diagnosis-related groups (DRGs):** Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are the case-mix measure mandated for Medicare's prospective hospital payment system by the Social Security Amendments of 1983 (Public Law 98-21).

**Fee-for-service payment:** A method of paying for medical care in which each service performed by an individual provider can bear a related charge.

**Fee schedule:** An exhaustive list of physician services in which each entry is associated with one specific monetary amount representing the approved payment for a given insurance plan.

**Hematuria:** The discharge of blood in the urine.

**Idiopathic:** Of unknown origin.

**Incidence:** The number of newly diagnosed cases of a condition over a specified period of time, usually a year.

**Inpatient services:** Services provided to patients who are hospitalized.

**Intermediaries (Medicare):** Organizations, typically Blue Cross plans or commercial insurance firms, under contract to the Health Care Financing Administration for administering Part A of the Medicare program. Their tasks include determining reasonable costs for covered items and services, making payments, and guarding against unnecessary use of covered services for Medicare Part A payments. Intermediaries also make payments for home health and outpatient hospital services covered under Part B.

**International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Coding:** A two-part system of coding patient medical information used in abstracting systems and for classifying patients into DRGs for Medicare. The first part is a comprehensive list of diseases with corresponding codes compatible with the World Health Organization's list of disease codes. The second part contains procedure codes, independent of the disease codes.

**Lithotripsy:** Stone destruction.

**Lithotripter:** An instrument that fragments, erodes, or otherwise destroys stones in the body.

**Medical technology:** The drugs, devices, and medical and surgical procedures used in medical care, and the organizational and support systems within which such care is provided.

**Nephrectomy:** The surgical removal of part of the kidney.

**Nephrolithotomy:** The surgical removal of a stone from the kidney.

**Nephrotomy:** A surgical incision into the kidney.

**Nephrostomy:** The establishment of a passageway through the body to the kidney.

**Opportunity cost:** In economics, defined as the return available from the best alternative use of a particular resource, for example, the value of the other products that might otherwise have been produced by the resources used in the production of a particular good or service. Any single opportunity taken will have a cost in terms of an opportunity forgone.

**Part A (Medicare):** Medicare's Hospital Insurance program, which provides insurance benefits against the costs of hospital and related posthospital services for elderly and disabled beneficiaries. Part A, which is an entitlement program for those who are eligible, is available without payment of a premium, although the beneficiary is responsible for an initial deductible or copayment for some services. Those not automatically eligible for Part A may enroll in the program by paying a monthly premium.

**Part B (Medicare):** Medicare's Supplementary Medical Insurance program, which provides insurance benefits for medically necessary physician services, hospital outpatient services, outpatient physical therapy and speech pathology services, comprehensive rehabilitation facility services, and various other limited ambulatory services and supplies such as prosthetic devices and durable medical equipment. Part B also covers home health services for those Medicare beneficiaries who have Part B coverage only. Part B is optional and requires payment of a monthly premium. The beneficiary is also responsible for a deductible and a coinsurance payment for most covered services.

**Percutaneous:** Literally, "through the skin"; refers to a surgical procedure that requires only a very small incision. In percutaneous nephrostolithotomy, a kidney stone is removed through a small incision and a channel to the stone, with endoscopic assistance, rather than through a large incision.

**Prevailing charge (Medicare):** In the absence of unusual medical circumstances, the maximum amount a Medicare carrier will approve for payment for a particular service provided by any physician practice within a particular peer group and locality. Generally, this amount is equal to the lowest charge in an array of customary charges that is high enough to include 75 percent of all the relevant customary charges.

**Prospective payment:** Payment for medical care on the basis of rates set in advance of the time period in which they apply. The unit of payment may vary from individual medical services to broader categories, such as hospital case, episode of illness, or person (cavitation).

**Prospective Payment Assessment Commission**

**(ProPAC):** A commission established by the same law that created the DRG-based prospective payment system for Medicare (Public Law 98-21) to make recommendations to the Secretary of Health and Human Services on the annual update factor and on adjustments of DRG classifications and weights.

**Pyelolithotomy:** The surgical removal of a stone from the renal pelvis.

**Quality of care:** The degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art.

**Reasonable and necessary services (Medicare):** Criteria used to determine what services are eligible for Medicare reimbursement. For some services, HCFA specifically allows or denies coverage; for other services, Medicare carriers and intermediaries themselves determine coverage policy.

**Reasonable charge:** See *approved charge*.

**Renal:** Pertaining to the kidney.

**Renal calix:** One of the finger-like projections of the renal pelvis that collect filtered urine and channel it into the kidney's core.

**Renal pelvis:** The hollow core of the kidney.

**Staghorn stone:** A large kidney stone that fills several calices, giving it a dramatic "staghorn" appearance in X-rays.

**Struvite stone:** A urinary stone composed of magnesium ammonium phosphate and associated with urinary tract infection.

**Third-party payment:** Payment by a private insurer or government program to a medical provider for care given to a patient.

**Transurethral:** Through the urethra. Refers to treatment procedures that use instruments passed up the urinary tract, rather than through a surgical incision.

**Ureter:** One of the two tube-like structures that carry urine from the kidneys to the bladder.

**Ureterolithotomy:** The surgical removal of stones from the ureter.

**Urethra:** The structure through which urine passes from the bladder out of the body.

**Urinary bladder:** The structure that collects urine from the ureters and stores it until urination.

**Urinary tract:** The organ system that consists of the kidneys, ureters, bladder, and urethra.

## Glossary of Acronyms

AHA	—American Hospital Association
ALOS	—average length of stay
AMA	—American Medical Association
AMI	—American Medical International
ASC	—ambulatory surgical center
AUA	—American Urological Association
CFR	—Code of Federal Regulations
CHAMPUS	—Civilian Health and Medical Program of the Uniformed Services (DOD)
CON	—certificate of need
CPHA	—Commission on Professional and Hospital Activities
CPT	—current procedural terminology
CT	—computed tomography
DOD	—Department of Defense
DRG	—diagnosis-related group
DHHS	—Department of Health and Human Services
ESWL	—extracorporeal shock wave lithotripsy
FDA	—Food and Drug Administration
FR	—Federal Register
HCA	—Hospital Corporation of America
HCFA	—Health Care Financing Administration (DHHS)
ICD-9-CM	—International Classification of Diseases, 9th Revision, Clinical Modification
IDE	—investigational device exemption
IHS	—Indian Health Service
MRI	—magnetic resonance imaging
NCHS	—National Center for Health Statistics
NME	—National Medical Enterprises
OHTA	—Office of Health Technology Assessment (Public Health Service)
PPS	—prospective payment system
ProPAC	—Prospective Payment Assessment Commission
R&D	—research and development
VA	—Veterans Administration
VHA	—Voluntary Hospitals of America
WHO	—World Health Organization