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Complete Healthcare Compliance Manual 2024
Healthcare Compliance Glossary

accountable care organization (ACO): Groups of doctors, hospitals, and other healthcare providers that voluntarily come together to provide coordinated high-quality care to their Medicare patients.

additional documentation request (ADR): If a claim is selected for review or needs additional documentation, an ADR letter is sent to the provider requesting that documentation and/or medical records be submitted. The response must be submitted within a specific time frame to the requesting Medicare contractor identified on the letter for review and payment determination.

adjusted average per capita cost (AAPCC): Centers for Medicare & Medicaid Services' best estimate for the amount of money it costs to care for Medicare recipients in a year under fee-for-service Medicare in a given area.

adjusted community rating: Under the Affordable Care Act (ACA), insurers can't raise premiums based on health status, medical claims, gender, or most of the other factors that they had previously used to determine rates prior to ACA implementation.

advance beneficiary notice of noncoverage (ABN): The ABN (Form CMS-R-131) is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee-for-service) beneficiaries when Medicare payment is expected to be denied. In certain situations, the ABN transfers potential financial liability to the Medicare beneficiary.

advisory opinion (of the OIG): A legal opinion issued by the Office of Inspector General (OIG) to one or more requesting parties about the application of the OIG's fraud and abuse authorities to the party's existing or proposed business arrangement. An OIG advisory opinion is legally binding on the Department of Health & Human Services and the requesting party or parties. It is not binding on any other government department or agency.

affiliated covered entity (ACE): Under the Health Insurance Portability and Accountability Act, legally separate covered entities under common ownership or control have an option to be treated as a single legal entity by choosing to designate as ACE. This enables the entities to share information in a way that would otherwise be impermissible (use vs. disclosure).

Agency for Healthcare Research and Quality: Agency within the Department of Health & Human Services (HHS) whose mission is to produce evidence to make healthcare safer, higher quality, more accessible, equitable, and affordable and to work with HHS and other partners to make sure that the evidence is understood and used.

Anti-Kickback Statute (AKS): Federal criminal statute that prohibits the exchange (or offer to exchange) of anything of value in an effort to induce (or reward) the referral of federal healthcare program business.

attestation: The affirmation by signature, usually on a printed form, that the action outlined has been accomplished by the individual signing (e.g., the individual has read the code of conduct and agreed to adhere to its principles).

attorney–client privilege: A legally accepted policy that communication between a client and attorney is confidential in the course of the professional relationship and that such communication cannot be disclosed

without the consent of the client. Its purpose is to encourage full and frank communication between attorneys and their clients.

audit, baseline: A systematic inspection of records, policies, and procedures with the goal to establish a set of benchmarks for comparison for future inspections.

audit, concurrent: An inspection of records, policies, and procedures at a given point in time in which identified potential problems are audited as they arise (e.g., documentation reviewed and codes substantiated prior to dropping a bill).

audit, retrospective: An audit of historical events (e.g., paid claims audits, executed contracts, etc.). How far back it goes can be determined by specific milestones or a legal statute (e.g., new or revised laws, new departments, new system, etc.).

Balanced Budget Act of 1997: Legislation containing major reform of the Medicare and Medicaid programs, especially in the areas of home health and patient transfers. It also mandated permanent exclusion from participation in federally funded healthcare programs of those convicted of three healthcare-related crimes.

bankruptcy: Legal status of person or entity that cannot repay the debts it owes to creditors.

benchmarking: The measurement of performance against best-practice standards.

best practices: Generally recognized superior performance by organizations in operational and/or financial processes.

business associate: A business associate is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information (PHI) on behalf of, or provides services to, a covered entity. A member of the covered entity's workforce is not a business associate. A covered healthcare provider, health plan, or healthcare clearinghouse can be a business associate of another covered entity. The Privacy Rule lists some of the functions or activities, as well as the particular services, that make a person or entity a business associate if the activity or service involves the use or disclosure of PHI. The types of functions or activities that may make a person or entity a business associate include payment or healthcare operations activities, as well as other functions or activities regulated by the Administrative Simplification Rules. Business associate functions and activities include claims processing or administration; data analysis, processing, or administration; utilization review; quality assurance; billing; benefit management; practice management; and repricing. Business associate services are legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, and financial. See the definition of "business associate" at 45 C.F.R. § 160.103 .

business associate agreement (BAA): The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires that, before protected health information (PHI) can be shared between a covered entity and a business associate, the business associate must sign a written agreement that gives satisfactory assurances that it will not use or disclose PHI in a manner that contradicts the Privacy Rule requirements. HIPAA also requires a business associate agreement to define the function of the business associate and the limitations on their uses and disclosures of PHI. The business associate agreement must also define what will happen to the PHI held by the business associate upon termination of the agreement.

Caremark International derivative litigation: The 1996 U.S. civil settlement of Caremark International Inc. in which an imposed corporate integrity agreement precluded Caremark from providing healthcare in certain forms for a period of five years. Also suggests that the failure of a corporate director to attempt in good faith to institute a compliance and ethics program in certain situations may be a breach of a director's fiduciary obligation.

Centers for Medicare & Medicaid Services (CMS): Previously known as the Health Care Financing Administration, the agency that administers the Medicare, Medicaid, and state Children's Health Insurance programs within the Department of Health & Human Services.

Certified Professional Coder (CPC): A coder who has satisfied certification requirements as established by the American Academy of Professional Coders.

Civil Monetary Penalties Law (CMPL): Regulations that apply to any claim for an item or service that was not provided as claimed or that was knowingly submitted as false and that provide guidelines for the levying of fines for such offences.

Civilian Health and Medical Program of the Uniformed Services: A federal program providing healthcare coverage to families of military personnel and others.

Clinical Laboratory Improvement amendments: Federal regulations that include federal standards applicable to all US facilities or sites that test human specimens for health assessment or to diagnose, prevent, or treat disease.

Committee of Sponsoring Organizations of the Treadway Commission (COSO): A joint initiative of five private-sector organizations that are dedicated to providing thought leadership through the development of frameworks and guidance on enterprise risk management, internal control, and fraud deterrence.

compliance: Adherence to the laws and regulations passed by official regulating bodies as well as general principles of ethical conduct. In the United States, such regulating bodies include the U.S. Congress, federal executive departments and federal agencies and commissions, and corresponding state-level entities.

conflict of interest: A conflict of interest occurs when an individual's private interest interferes in any way—or even appears to interfere—with the interests of the corporation as a whole. A conflict situation can arise when an employee, officer, or director takes action or has interests that may make it difficult to perform their company work objectively and effectively.

Consolidated Omnibus Budget Reconciliation Act (COBRA): Continuation health coverage legislation that gives employees and families who lose health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances.

Consumer Assessment of Healthcare Providers & Systems: An initiative by the federal government for Medicare & Medicaid the aim of which is to develop a set of satisfaction surveys built off of a core of standardized items and supplemented by additional targeted elements to make the surveys both adaptable to different subpopulation and suitable for making some cross-group comparisons.