Glossary of Common Terminology Related to Facility Fees
HB23-1215 Steering Committee
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837 – Standard format for sending health care claims electronically

837P The 837P (Professional) is the standard format health care providers and suppliers use to send health care claims electronically.

837I - The 837I (Institutional) is the standard format institutional providers use to send health care claims electronically

Ambulatory care- Ambulatory care refers to medical services performed on an outpatient basis, without admission to a hospital or other facility. Ambulatory care is provided in settings such as dialysis clinics, ambulatory surgical centers, hospital outpatient departments, and the offices of physicians and other health professionals.

Ambulatory surgical center - a health care entity established for the primary purpose of providing medically necessary surgery, elective surgery, or preventive diagnostic procedures that do not require hospitalization but do require post surgical or post procedural observation and monitoring that generally will not exceed 24 hours from admission to discharge.

Balance bill - (I) The amount that an out-of-network provider may charge a covered person for the provision of health-care services, which amount equals the difference between the amount paid by the carrier for the health-care services and the amount of the out-of-network provider's billed charge for the health-care services; and

(II) The act of a nonparticipating provider charging a covered person the difference between the billed amount and the amount the carrier paid the provider.

Campus - a hospital's main buildings; the physical area immediately adjacent to a hospital's main buildings and structures owned by the hospital that are not strictly contiguous to the main building but are located within 250 yards of the main building; or any other area that the federal Centers for Medicare and Medicaid Services (CMS) has determined, on an individual-case basis, to be part of a hospital's campus.

Centers for Medicare and Medicaid Services (CMS) - a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace.

Charge Description Master (CDM) – also referred to as the Chargemaster, is the comprehensive list of all the billable services and items to a patient or a patient's health insurance provider. The chargemaster captures the costs of each procedure, service, supply, prescription drug, and diagnostic test provided at the hospital, as well as any fees associated with services, such as equipment fees and room charges. (HCG)

Clinical Integration - Clinical integration enables greater collaboration on care delivery within and across settings of care, which in turn improves the patient experience. Clinically integrated hospitals and other providers work together across settings of care to establish consistent practices in areas such as quality assurance, utilization review, guidelines and protocols, as well as coordination of patient services and shared access to medical records.

CMS 1500 (aka HCFA 1500) - The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional carriers (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims.

Co-insurance - The percentage that the beneficiary pays after the insurance policy's deductible is exceeded.

Congressional Budget Office (CBO) - a federal agency within the legislative branch of the United States government that provides budget and economic information to Congress.

Co-pay - A fixed amount for a covered service, paid by a patient to the provider of service before receiving the service. The amount can vary by the type of covered healthcare service and is a standard part of many health insurance plans. Insurance companies often charge copays for things such as doctor visits or prescription drugs. (HCG)

CPT A/M - *[need clarification and definition]*

Critical access hospital (CAH) – a CMS designation for hospitals that meeting the following requirements:

- Be designated by the State as a CAH;
- Be located in a rural area or an area that is treated as rural;
- Be located either more than 35-miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads; OR prior to January 1, 2006, were certified as a CAH based on State designation as a "necessary provider" of health care services to residents in the area. • Maintain no more than 25 inpatient beds that can be used for either inpatient or swing-bed services;
- Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care (excluding swing-bed services and beds that are within distinct part units);
- Demonstrate compliance with the CAH CoPs found at 42 CFR Part 485 subpart F; and
- Furnish 24-hour emergency care services 7 days a week.

Current Procedural Terminology (CPT) - a uniform language healthcare professionals use for coding medical services and procedures to streamline reporting, and to increase accuracy and efficiency.

Deductible - health care expenses the beneficiary must pay before insurance applies.

Differential payment rates -Differential that recognizes a physician's practice expense is generally lower when services are provided in a facility setting. When a procedure is performed in a facility setting the physician uses hospital resources rather than their own therefore reducing the practice expense for the physician.

Electronic Data Interchange (EDI) Transactions: EDI transactions are the transmittal of any health information in electronic form. The transactions for which Health Insurance Portability & Accountability Act (HIPAA) standards have been adopted or proposed range from health plan premium payments to health care claim submissions to health claim attachments.

Emergency Department (ED) – a portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

Essential Community Hospital – *[Definition needed]*

Evaluation and Management (E&M) - services by a physician (or other health care professional) in which the provider is either evaluating or managing a patient's health.

Explanation of Benefits (EOB) – a statement sent by the insurance company to the insurer explaining the total charges for the healthcare services provided, how the insurance company processed the claim, how much the health insurance company paid and how much the patient owes for the services provided. (HCG)

Facility fees – Any fee a hospital or health system charges or bills for outpatient hospital services that is intended to compensate the hospital or health system for its operational expenses and separate and distinct from a professional fee charged or billed by a health-care provider for professional medical services.

Financial Integration - Financial integration means that facilities share income and expenses, allowing for greater access to resources and an ability to spread costs over larger populations, leading to efficiencies in overhead, administrative expenses and infrastructure.

Freestanding ED – a health facility that offers emergency care, that may offer primary and urgent care services, and that is either:

(A) Owned or operated by, or affiliated with, a hospital or hospital system and located more than two hundred fifty yards from the main campus of the hospital; or

(B) Independent from and not operated by or affiliated with a hospital or hospital system and not attached to or situated within two hundred fifty yards of, or contained within, a hospital.

Frontier Hospital – A hospital located in a county with a population of six or fewer persons per square mile. Bureau of Primary Health Care established as policy a frontier service area definition identified as any service area with a population density less than or equal to six persons per square mile.

Government Accountability Office (GAO) - an independent, nonpartisan government agency within the legislative branch that provides auditing, evaluative, and investigative services for the United States Congress.

Grouper - In the context of health care revenue cycle management, a grouper refers to a software tool or algorithm used to assign diagnosis-related groups (DRGs) or other grouping methodologies to patient encounters or claims. The primary purpose of a grouper is to categorize patients into specific groups based on their diagnoses, procedures, and other relevant factors. This grouping process is crucial for accurate reimbursement, as it helps determine the appropriate payment amount for healthcare services provided.

Hard Coded – the process of automatically assigning codes through charge entry process (without human intervention), which applies codes using the chargemaster, most often used for simple services where code values rarely change. (HCG)

HCPCS Codes – stands for the Healthcare Common Procedure Coding System, a standardized coding system categorized into two levels: Level I (also known as Current Procedural Technology, or CPT codes) and Level II codes, used to identify products, supplies and services not included in CPT. (HCG)

Healthcare professional - Physicians, nurse practitioners, physician assistants, physical therapists, and other individually licensed or certified health care providers.

Healthcare system - An organization of people, institutions, and resources that delivers health care services to meet the health needs of target populations.

High-acuity services - *[need definition]*

Horizontal integration - Horizontal integration occurs when two or more like providers, such as two hospitals, join forces. Horizontal integration helps groups of like providers gain economies of scale by purchasing supplies and drugs at lower costs, eliminating inefficiencies, removing duplicative service lines and technologies, and consolidating common services and functions, including revenue cycle management and human resources.

Hospital - "General hospital" means a health facility that, under an organized medical staff, offers and provides inpatient services, emergency medical and emergency surgical care, continuous nursing services, and necessary ancillary services, to individuals for the diagnosis or treatment of injury, illness, pregnancy, or disability, twenty-four (24) hours per day, seven (7) days per week.

(A) A general hospital may offer and provide, but is not limited to, outpatient, preventive, therapeutic, surgical, diagnostic, rehabilitative, or any other supportive services for periods of less than twenty-four (24) hours per day.

(B) Services provided by a general hospital may be provided directly or by contractual agreement. Direct inpatient services shall be provided on the licensed premises of the general hospital.

(C) A general hospital may provide services on its campus and on off-campus locations.

(D) Non-direct care services (such as billing functions) necessary for the successful operation of the hospital that are not on the hospital campus may be incorporated under the license.

ICD-10-CM Code – stands for the International Classification of Diseases, Tenth Revision (ICD-10), a standardized coding system used to classify all diagnoses. Diagnosis codes are required on a medical claim to determine whether the patient's diagnosis(es) are medically necessary to justify the services received. (HCG)

Independent provider – A provider that is not affiliated with a hospital.

Inpatient hospital services– . Subject to the conditions, limitations, and exceptions set forth in this subpart, the term "inpatient hospital or inpatient CAH services" means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

- Bed and board.
- Nursing services and other related services.
- Use of hospital or CAH facilities.
- Medical social services.
- Drugs, biologicals, supplies, appliances, and equipment.
- Certain other diagnostic or therapeutic services.
- Medical or surgical services provided by certain interns or residents-in-training.
- Transportation services, including transport by ambulance.

Low-acuity services – *[need definition]*

Medical Coding Modifier – a two-character alphanumeric value appended to a CPT or HCPCS code to provide additional information about the medical procedure, service, or supply without changing the meaning of the code. Modifiers provide a mechanism to communicate special or specific circumstances related to the performance of a procedure or service. (HCG)

Medicare Payment Advisory Commission (MedPAC) – A nonpartisan independent legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program.

National Provider Identifier (NPI) - A federally assigned unique identification number for health care providers to use for administrative and financial transactions.

Non-Excepted HOPD - *[need definition]*

Off-Campus Location - means a facility that meets all of the following criteria: (A) Whose operations are directly or indirectly owned or controlled by, in whole or in part, or affiliated with a hospital, regardless of whether the operations are under the same governing body as the hospital; (B) That is located more than two hundred fifty (250) yards from the hospital's main campus; (C) That provides services that are organizationally and functionally integrated with the hospital; (D) That is an outpatient facility providing preventative, diagnostic, treatment, or emergency services; and (E) That is not otherwise subject to regulation under 6 CCR 1011-1.

Off Campus Hospital Services. These are services provided by a hospital entity that are not on campus. Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

Outpatient hospital services - Medical or surgical care that does not include an overnight hospital stay. Medical or surgical care received from a clinic or hospital but not admitted as an inpatient. Outpatient care may include emergency department services, observation services, outpatient surgery, lab tests or X-rays.

Outpatient Prospective Payment System (OPPS) – the system for payment used by CMS to reimburse for hospital outpatient services. All items and services paid for under the OPPS are assigned a payment group called Ambulatory Payment Classification (APCs) which group together items and services that are similar clinically and in terms of resource use.

Owned-by - owned by a hospital or health system when billed under the hospital's tax identification number.

Patient financial liability/cost sharing/out of pocket cost – The portion of a medical bill that patient needs to pay to cover their treatment costs. This may come in the form of co-pays, co-insurance or deductibles.

Payer mix – *Payer Mix is a term used in healthcare revenue cycle management to describe the percentage of patients who are covered by different types of payers, such as commercial insurance, Medicare, Medicaid, and self-pay. Payer Mix is calculated by determining the percentage of revenue generated by each payer type. (MDclaity.com)*

Payer type - commercial insurers; Medicare; the Medical Assistance Program established pursuant to Articles 4 to 6 of Title 25.5; Individuals who self-pay; a financial assistance plan; or the "Colorado Indigent Care Program," established in Part 1 of Article 3 of Title 25.5.

Place of Service Codes (POS) – a two-digit code placed on a 1500 claim form to indicate the setting in which the professional healthcare services were provided. The Centers for Medicare and Medicaid Services (CMS) mains the standardized POS codes used throughout the healthcare industry. (HCG)

Private equity - A privately-held company that does not offer stock to the general public.

Professional Fee Coding – also known as 'profee' coding, refers to the process of coding and billing the services provided by individual healthcare professionals. Profee coding covers the work performed by the provider and the associated reimbursement they will receive for the services provided. (HCG)

Professional service fee - Charges health care professionals, including physicians, nurse practitioners, physician assistants, and physical therapists, bill for their services. Any claim submitted using the HIPAA mandated transaction ASC X12 837 professional claim or the CMS-1500 paper claim form.

Prospective Payment System (PPS) – a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation services, long-term care hospitals, and skilled nursing facilities. (HCG)

Provider-based status - Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of 42 CFR § 413.65.

Revenue Code – a 4-digit code (including a leading zero) that indicates the type or location of the service or item the patient received. Standard revenue codes are used to group similar types of charges together. For example, Rev Code 0450 is used for Emergency Room (ER) services. Revenue Codes are mandatory for hospital billing and are paired with procedure codes. (HCG)

Rural hospital - Rural hospitals are those hospitals not located within a metropolitan area as defined by the U.S. Office and Management and Budget and the U.S. Census Bureau. The Census does not define "rural." They consider "rural" to include all people, housing, and territory that are not within an urban area. Any area that is not urban is rural. The Census defines urban as: Urbanized Areas (UAs) of 50,000 or more people and Urban Clusters (UCs) of 2,500 - 49,999 people.

Site-neutral payments - paying the same rates for the same service across different sites of care if the care can safely and effectively be provided in a lower cost setting.

Soft Coded – the process of manually reviewing associated documenting and assigning the appropriate code(s), most often used when the procedure or services being coded have a high rate of variability, such as complex procedures and surgeries. (HCG)

Sole Community Hospital – CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in § 412.64) and meets one of the following conditions:

(1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:

(i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;

(ii) The hospital has fewer than 50 beds and the MAC certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or

(iii) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

(4) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, combined data from the main campus and its remote location(s) are required to demonstrate that the criteria specified in paragraphs (a)(1)(i) and (ii) of this section are met. For the mileage and rural location criteria in paragraph (a) of this section and the mileage, accessibility, and travel time criteria specified in paragraphs (a)(1) through (3) of this section, the hospital must demonstrate that the main campus and its remote location(s) each independently satisfy those requirements.

Taxpayer Identification Number (TIN) - An identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. Note: A TIN is assigned to each practice for tax purposes and NPIs are used to identify individual health care providers. TINs were developed by the IRS and NPIs were developed by CMS.

Technical fees – another term for facility fees.

Vertical integration - Vertical integration refers to integration of providers at different points along the continuum of care, such as a hospital partnering with a skilled nursing facility (SNF) or a physician group. Vertical integration can facilitate lower costs and, ultimately, better patient outcomes. Specifically, better communication and information sharing among providers across the continuum of care provides the foundation for care coordination, with benefits such as reducing readmissions or minimizing redundant testing.

UB-04 (aka CMS/HCFA 1450) - the uniform medical billing form (or UB for short) is the standard claim form used by institutional providers to bill insurers for services rendered. Examples of institutional providers include hospitals, outpatient physical therapy services, skilled nursing facilities (SNF), and hospices. (HCG). The same information is conveyed via the HIPAA X12 837I electronic claims transaction.