National Medicare TRAINING PROGRAM

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Glossary of Terms

Term to Know	Definition
Advance Beneficiary Notice (ABN)	In Original Medicare, a notice that a doctor, supplier, or provider gives a Medicare beneficiary before furnishing an item or service if the doctor, supplier, or provider believes that Medicare may deny payment. In this situation, if you aren't given an ABN before you get the item or service, and Medicare denies payment, then you may not have to pay for it. If you are given an ABN, and you sign it, you will probably have to pay for the item or service if Medicare denies payment.
Advance coverage decision	A notice you get from a Medicare Advantage Plan letting you know in advance whether it will cover a particular service.
Advance directive	A written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a living will and a durable power of attorney for health care.
ALS	Amyotrophic lateral sclerosis, also known as Lou Gehrig's disease.
Ambulatory surgical center	A facility where simpler surgeries are performed for patients who aren't expected to need more than 24 hours of care.
Appeal	An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of the following: • Your request for a health care service, supply, or prescription that you think you should be able to get • Your request for payment for health care or a prescription drug you already got • Your request to change the amount you must pay for a prescription drug • You can also appeal if you're already getting coverage and Medicare or your plan stops paying.
Assignment	An agreement by your doctor or other supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefit period	The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.
Certified (certification)	See "Medicare-certified provider"
Claim	A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered.
Clinical breast exam	An exam by your doctor or other health care provider to check for breast cancer by feeling and looking at your breasts. This exam isn't the same as a mammogram and is usually done in the doctor's office during your Pap test and pelvic exam.
Coinsurance	An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).
Comprehensive outpatient rehabilitation facility	A facility that provides a variety of services on an outpatient basis, including physicians' services, physical therapy, social or psychological services, and rehabilitation.
Copayment	An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.
Coverage determination (Part D)	The first decision made by your Medicare drug plan (not the pharmacy) about your drug benefits, including the following: • Whether a particular drug is covered • Whether you've met all the requirements for getting a requested drug • How much you're required to pay for a drug • Whether to make an exception to a plan rule when you request it If the drug plan doesn't give you a prompt decision and you can show that the delay would affect your health, the plan's failure to act is considered to be a coverage determination. If you disagree with the coverage determination, the next step is an appeal.

Coverage gap (Medicare prescription drug coverage)	A period of time in which you pay higher cost sharing for prescription drugs until you spend enough to qualify for catastrophic coverage. The coverage gap (also called the "donut hole") starts when you and your plan have paid a set dollar amount for prescription drugs during that year.
Creditable coverage	See "creditable coverage (Medigap)" or "creditable prescription drug coverage"
Creditable coverage (Medigap)	Previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medigap policy.
Creditable prescription drug coverage	Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.
Critical access hospital (CAH)	A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.
Custodial care	Non-skilled personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.
Deductible	The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.
Demonstrations	Special projects, sometimes called "pilot programs" or "research studies," that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and in specific areas.
Diethylstilbestrol (DES)	A drug given to pregnant women from the early 1940s until 1971 to help with common problems during pregnancy. The drug has been linked to cancer of the cervix or vagina in women whose mother took the drug while pregnant.
Drug list	A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. This list is also called a formulary.
Durable medical equipment	Certain medical equipment, such as a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

Durable power of attorney	A legal document that enables you to designate another person to act on your behalf in the event you become disabled or incapacitated.
End-Stage Renal Disease (ESRD)	Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.
Exception	A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that's on its non-preferred drug tier. You must request an exception, and your doctor or other prescriber must send a supporting statement explaining the medical reason for the exception.
Excess charge	If you have Original Medicare, and the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount, the difference is called the excess charge.
Extra Help	A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.
Formulary	A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.
Grievance	A complaint about the way your Medicare health plan or Medicare drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person at the plan has behaved towards you. However, if you have a complaint about a plan's refusal to cover a service, supply, or prescription, you file an appeal.
Group health plan	In general, a health plan offered by an employer or employee organization that provides health coverage to employees, former employees, and their families.
Guaranteed issue rights (also called "Medigap protections")	Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy, or place conditions on a Medigap policy, such as exclusions for pre-existing conditions, and can't charge you more for a Medigap policy because of a past or present health problem.
Guaranteed renewable policy	An insurance policy that can't be terminated by the insurance company unless you make untrue statements to the insurance company, commit fraud, or don't pay your premiums. All Medigap policies issued since 1992 are guaranteed renewable.

Health care provider	A person or organization that's licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.
Home health agency	An organization that provides home health care.
Home health care	Health care services and supplies a doctor decides you may receive in your home under a plan of care established by your doctor. Medicare only covers home health care on a limited basis as ordered by your doctor.
Hospice	A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.
Independent reviewer	An organization (sometimes called an Independent Review Entity or IRE) that has no connection to your Medicare health plan or Medicare Prescription Drug Plan. Medicare contracts with the IRE to review your case if you appeal your plan's payment or coverage decision or if your plan doesn't make a timely appeals decision.
Inpatient rehabilitation facility	A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.
Large group health plan	In general, a group health plan that covers employees of either an employer or employee organization that has 100 or more employees.
Lifetime reserve days	In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.
Limiting charge	In Original Medicare, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.
Living will	A legal document also known as a medical directive or advance directive. It states your wishes regarding life-support or other medical treatment in certain circumstances, usually when death is imminent.
Long-term care	A variety of services that help people with their medical and non-medical needs over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.

Long-term care hospital	Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.
Long-term care ombudsman	An independent advocate (supporter) for nursing home and assisted living facility residents who works to solve problems between residents and nursing homes or assisted living facilities. They may be able to provide information about home health agencies in their area.
Medicaid	A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
Medicaid-certified provider	A health care provider (like a home health agency, hospital, nursing home, or dialysis facility) that has been approved by Medicaid. Providers are approved or "certified" if they have passed an inspection conducted by a state government agency.
Medical underwriting	The process that an insurance company uses to decide, based on your medical history, whether to take your application for insurance, whether to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.
Medically necessary	Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.
Medicare	The federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Medicare Advantage Plan (Part C)	A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.
Medicare-approved amount	In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare-certified provider	A health care provider (like a home health agency, hospital, nursing home, or dialysis facility) that has been approved by Medicare. Providers are approved or "certified" by Medicare if they have passed an inspection conducted by a state government agency. Medicare only covers care given by providers who are certified.
Medicare Coordination of Benefits Contractor	The company that acts on behalf of Medicare to collect and manage information on other types of insurance or coverage that a person with Medicare may have, and determine whether the coverage pays before or after Medicare.
Medicare Cost Plan	A type of Medicare health plan available in some areas. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under Original Medicare (your Cost Plan pays for emergency services or urgently needed services).
Medicare Health Maintenance Organization (HMO) Plan	A type of Medicare Advantage Plan (Part C) available in some areas of the country. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Most HMOs also require you to get a referral from your primary care physician.
Medicare health plan	A plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).
Medicare Medical Savings Account (MSA) Plan	MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare into the account. You can use the money in this account to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount so you generally will have to pay out-of-pocket before your coverage begins.
Medicare Part A (hospital insurance)	Coverage for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
Medicare Part B (medical insurance)	Coverage for certain doctors' services, outpatient care, medical supplies, and preventive services.
Medicare plan	Any way other than Original Medicare that you can get your Medicare health or prescription drug coverage. This term includes all Medicare health plans and Medicare Prescription Drug Plans.

Medicare Preferred Provider Organization (PPO) Plan	A type of Medicare Advantage Plan (Part C) available in some areas of the country in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.
Medicare prescription drug coverage (Part D)	Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.
Medicare Prescription Drug Plan (Part D)	A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.
Medicare Private Fee-For-Service (PFFS) Plan	A type of Medicare Advantage Plan (Part C) in which you can generally go to any doctor or hospital you could go to if you had Original Medicare, if the doctor or hospital agrees to treat you. The plan determines how much it will pay doctors and hospitals, and how much you must pay when you get care. A Private Fee-For-Service Plan is very different than Original Medicare, and you must follow the plan rules carefully when you go for health care services. When you're in a Private Fee-For-Service Plan, you may pay more or less for Medicare-covered benefits than in Original Medicare.
Medicare Savings Program	A Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance.
Medicare SELECT	A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.
Medicare Special Needs Plan (SNP)	A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or have certain chronic medical conditions.
Medicare Summary Notice (MSN)	A notice you get after the doctor or provider files a claim for Part A or Part B services in Original Medicare. It explains what the doctor or provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.
Medigap Open Enrollment Period	A one-time-only, 6-month period when federal law allows you to buy any Medigap policy you want that's sold in your state. It starts in the first month that you're covered under Part B and you're age 65 or older. During this period, you can't be denied a Medigap policy or charged more due to past or present health problems. Some states may have additional open enrollment rights under state law.

Medigap policy	Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.
Multi-employer plan	In general, a group health plan that's sponsored jointly by 2 or more employers.
Original Medicare	Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.
Out-of-pocket costs	Health or prescription drug costs that you must pay on your own because they aren't covered by Medicare or other insurance.
Pap test	A test to check for cancer of the cervix, the opening to a woman's uterus. It's done by removing cells from the cervix. The cells are then prepared so they can be seen under a microscope.
Pelvic exam	An exam to check if internal female organs are normal by feeling their shape and size.
Penalty	An amount added to your monthly premium for Part B or a Medicare drug plan (Part D) if you don't join when you're first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.
Pilot programs	See "demonstrations."
Point-of-service option	In a Health Maintenance Organization (HMO), this option lets you use doctors and hospitals outside the plan for an additional cost.
Power of attorney	A medical power of attorney is a document that lets you appoint someone you trust to make decisions about your medical care. This type of advance directive also may be called a health care proxy, appointment of health care agent, or a durable power of attorney for health care.
Pre-existing condition	A health problem you had before the date that a new insurance policy starts.
Premium	The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.
Preventive services	Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).
Primary care doctor	The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Programs of All-Inclusive Care for the Elderly (PACE)	A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically-necessary care and services based on your needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.
Quality Improvement Organization (QIO)	A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to people with Medicare.
Recovery contractor	A company that acts on behalf of Medicare to obtain repayment when Medicare makes a conditional payment and the other payer is determined to be primary.
Referral	A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.
Rehabilitation services	Services that help you regain abilities, such as speech or walking, that have been impaired by an illness or injury. These services are given by nurses, and physical, occupational and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.
Religious nonmedical health care institution	A facility that provides nonmedical health care items and services to people who need hospital or skilled nursing facility care, but for whom that care would be inconsistent with their religious beliefs.
Respite care	Temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.
Secondary payer	The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.
Service area	A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.
Skilled nursing care	Care such as intravenous injections that can only be given by a registered nurse or doctor.

Skilled nursing facility (SNF)	A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.
Skilled nursing facility (SNF) care	Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.
State Health Insurance Assistance Program (SHIP)	A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.
State Insurance Department	A state agency that regulates insurance and can provide information about Medigap policies and other private health insurance.
State Medical Assistance office	A state agency that's in charge of the State's Medicaid program and can give information about programs that help pay medical bills for people with limited income and resources.
State Pharmacy Assistance Program (SPAP)	A state program that provides help paying for drug coverage based on financial need, age, or medical condition.
State Survey Agency	A state agency that oversees health care facilities that participate in the Medicare and/or Medicaid programs. The State Survey Agency inspects health care facilities and investigates complaints to ensure that health and safety standards are met.
Supplemental Security Income (SSI)	A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits aren't the same as Social Security retirement or disability benefits.
Supplier	Generally, any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.
Telemedicine	Medical or other health services given to a patient using a communications system (like a computer, telephone, or television) by a practitioner in a location different than the patient's.
TTY	A teletypewriter (TTY) is a communication device used by people who are deaf, hard-of-hearing, or have a severe speech impairment. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

Urgently needed care	Care that you get outside of your Medicare health plan's service area for a sudden illness or injury that needs medical care right away but isn't life threatening. If it's not safe to wait until you get home to get care from a plan doctor, the health plan must pay for the care.
Workers' compensation	A plan that employers are required to have to cover employees who get sick or injured on the job.