MEDICAL AND INSURANCE TERMINOLOGY

accident and health (A & H). Accident and health coverage is a feature of all group insurance except group life insurance. It is also referred to as accident and sickness, casualty, and disability coverage. The insurance industry’s new general term is health insurance.

accident and sickness (A & S). Accident and sickness coverage, although sometimes used as synonymous with accident and health coverage, usually refers to weekly indemnity insurance (loss-of-time, short-term disability income coverage). See loss-of-time benefits.

accumulation period. The maximum length of time an individual has to incur covered expenses that satisfy a required deductible.

active life reserve. The reserve for potential disability claims on currently insured active (not disabled) lives.

actively-at-work requirement. A form of individual evidence of insurability, because the insured’s health must be at least sound enough for him or her to be actively at work at his or her usual place of employment on the date the insurance takes effect. Because this definition is impractical for dependents, there is usually a provision that if a dependent is confined in a hospital on the date the insurance would otherwise become effective, the effective date of his or her insurance will be deferred until his or her release from the hospital.

activities of daily living (ADLs). Activities in the nonoccupational environment arising from daily living needs (e.g., mobility, personal hygiene, dressing, sleeping, eating, and skills required for community living).

adjustor. A person who handles claims (also referred to as a claims service representative).
appeal. A formal request to reconsider a determination not to certify an admission, extension of stay, or other medical service.

appeal committee. A management group not involved in initial claims decisions; it reviews denials (partial or full) when appealed by the claimant. It is an employee's right (as mandated by ERISA) to have a full and fair review of his or her case when a service is denied. The appeal committee reviews the claims file, the documentation of the denial, and the plan provision that was used to deny. It is the “court of last resort” and requires complete documentation to uphold a denial.

appropriateness of care. Care is considered appropriate if it is the right kind of care rendered in a proper setting.

assessment. The ongoing process of analyzing and integrating data obtained from the patient and family, relevant treatment providers, caregivers, and funding sources in order to identify the present plan of care, current and anticipated needs, and problems or obstacles that may be resolved through case management intervention.

assurance (insurance). The spreading of risk among many, with the likelihood that some will suffer a loss. The term assurance is more common in Canada and Great Britain; the term insurance is more common in the United States.

attending physician. The physician with primary responsibility for the care provided to a patient in a hospital or other health care facility.

authorization to pay benefits. A provision in a medical claim form by which the insured directs the insurance company to pay any benefits directly to the provider of care on whose charges the claim is based.

automatic reinsurance. A type of reinsurance in which the insurer must cede and the reinsuring company must accept all risks within certain contractually defined areas (also called treaty reinsurance). The reinsuring company undertakes in advance to grant reinsurance to the extent specified in the agreement in every case in which the ceding company accepts the application and retains its own limit.

benefits. The amount payable by an insurance company to the claimant, assignee, or beneficiary under a specific coverage.

bill audit. The review of hospital, physician, durable medical equipment, and health care service provider bills for inaccuracies or overbilling.
business alliances. Groups of business companies allied together to reduce health care costs by jointly purchasing medical services.

capitation. A method of payment for health services in which the health care provider is paid a fixed amount for each person over a specific amount of time regardless of the actual number or nature of services provided to each person.

caregiver. A family member, volunteer, or medical professional charged with providing care in the home setting.

carrier. The insurance company or other entity that agrees to pay the losses. A carrier may be organized as a company (stock, mutual, or reciprocal) or as an association of underwriters (e.g., Lloyds of London).

case reserve. The dollar amount stated in a claims file that represents an estimate of the amount still unpaid.

certification. A determination by a utilization review organization that an admission, extension of stay, or other medical service has been provided and qualifies as medically necessary and appropriate under the medical review requirements of the applicable health benefit plan.

claim. A request for payment of reparation for a loss covered by an insurance contract.

claimant. The person filing the claim to whom benefits are to be paid by the claims administrator.

claims administrator. Any entity that reviews and determines whether to pay claims to enrollees, physicians, or hospitals on behalf of the health benefit plan. Payment determinations are made on the basis of contract provisions, including those regarding medical necessity, and other factors. Claims administrators may be insurance companies, self-insured employers, management firms, Third Party Administrators, or other private contractors.

claims cost control. Efforts made by an insurer both inside and outside its own organization to restrain and direct claims payments so that health insurance premium dollars are used as efficiently as possible.

claims reserves. Funds reserved by an insurer to settle incurred but unpaid claims; may also include reserves for potential claims fluctuation.
claims service representative. A person who investigates losses and settles claims for an insurance carrier or the insured. Adjustor is a synonymous, although less preferred, term.

clinical experience. Expertise gained through professional clinical practice (e.g., any combination of direct patient care in a specialty area, home health, or general clinical area for which the applicant is licensed or certified).

coinsurance. A provision under a health insurance policy whereby the consumer assumes a percentage of the costs of covered services.

complementary and alternative medicine (CAM). The use of complementary and alternative care treatments is still considered controversial or “unorthodox” in some quarters; however, especially given the increased cultural diversity of our patient populations, they are among the most appropriate healing techniques for certain patients. Classified as mind/body/spirit treatment, holistic medicine, and Eastern medicine, these alternative approaches can refer to acupuncture, guided imagery, dietary therapy, Chinese medicine, spiritual healing, herbal remedies, homeopath, meditation, craniosacral therapy, chiropractic care, massage including Reiki, fertility treatments, paranormal healing, Tai Chi, and Yoga, among others.

comprehensive major medical insurance. A form of major medical expense insurance (written with an initial deductible) that can substitute for separate policies providing basic hospital, surgical, and medical benefits.

concurrent insurance. Insurance of a person under two or more policies providing similar or identical coverages (usually avoided in group insurance).

concurrent review. A form of utilization review that tracks the progress of a patient during treatment; conducted on-site or by telephone.

contingency reserve. A reserve established to share among all policyholders the cost to the insurer of unpredictable catastrophic losses.

coordination of benefits (COB). A method of integrating benefits payable under more than one group health insurance plan so that the insured’s benefits from all sources do not exceed 100% of his or her allowable medical expenses. Another method, based on a strict benefit-by-benefit (or “carve-out”) calculation, could result in zero payment by an insurer other than the one that pays benefits first.
co-payment. The portion of a claim or medical expense that a claimant must pay out of pocket.

cost-based or cost-related reimbursement. One method of payment of medical care programs by third parties, typically Blue Cross plans or government agencies, for services delivered to patients. In cost-related systems, the amount of the payment is based on the costs to the provider of delivering the service. The actual payment may be based on any one of several different formulas, such as full cost, full cost plus an additional percentage, allowable costs, or a fraction of costs. Other reimbursement schemes are based on the charges for fraction of costs, on the charges for the services delivered, or on budgeted or anticipated costs for a future time period (prospective reimbursement).

cost containment. The control of the overall cost of health care services within the health care delivery system. Costs are contained when the value of the resources committed to an activity are not considered to be excessive.

coverage. (1) The aggregate of risks insured by a contract of insurance; (2) a major classification of benefits provided by a group policy (e.g., term life, weekly indemnity, major medical); (3) the amount of insurance or benefits stated in the group policy for which an insured is eligible.

covered charges. Charges for medical care or supplies that, if incurred by an insured or other covered person, create a liability for the insurance under the terms of a group policy.

cultural and linguistic competence in health. A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

defensive medicine. The increased use of laboratory tests, hospital admissions, and extended lengths of stays in hospital by physicians for the principal purpose of forestalling the possibility of malpractice suits by patients and providing a good legal defense in the event of such lawsuits.

diagnosis-related groups (DRGs). Groupings of patients by discharge diagnosis to measure a hospital’s output. These are used for analysis and monitoring of the hospital’s resource utilization performance and costs.

direct contract model. A health plan that contracts directly with private practice physicians rather than through an independent practice association or medical group.
Appendix B

direct costs. Administration costs directly attributable to particular group cases and excluding any share of overhead expenses.

disability. A condition that makes an individual unable to earn full wages by doing the work performed when the individual was last employed.

disability benefit. A payment that arises because of total or permanent disability of an insured; a provision added to a policy that provides for a waiver of premium in case of total and permanent disability.

disability income insurance. A form of health insurance that provides periodic payments to replace income when an insured person is unable to work as a result of illness or injury.

discharge planner. The individual who assesses a patient’s need for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

discharge planning. The process that assesses a patient’s need for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

e-Health. A term that applies to the use of electronic technologies and telecommunications in the practice of clinical health care, patient and professional health-related education, public health, and health medicine. It includes the fields of telemedicine, teleHealth, medical informatics, electronic patient records, supply chain management, and biotechnologies.

enrollee. The individual who has elected to contract for or participate in a health benefit plan for him- or herself or his or her dependents.

exclusion. A specific illness or treatment that is expressly not covered by a plan or insurance contract.

exclusive provider organization (EPO). A form of PPO in which any services rendered by a nonaffiliated provider are not reimbursed, and the entire cost must be paid out of pocket by the claimant. EPO providers are usually reimbursed on a fee-for-service basis according to a negotiated discount or fee schedule.

fee-for-service. A form of reimbursement in which physicians and hospitals are paid a “reasonable or customary” fee for a unit of service; also, a system for the payment of professional services in which the
practitioner is paid for the particular service rendered rather than receiving a salary for services provided during scheduled work or on-call hours.

**gatekeeper.** A primary care provider who authorizes all specialist referrals. Use of gatekeepers is an essential feature of HMOs.

**group model HMO.** An HMO that contracts with a group of physicians who are paid a set salary per patient to provide a predetermined range of services.

**group practice.** Three or more physicians who deliver patient care, jointly use medical equipment and personnel, and divide income by a predetermined formula.

**Guided Care Model.** Guided Care is a new solution to the growing challenge of caring for older adults with chronic conditions and complex health needs. A Guided Care Nurse, based in a primary care office, works with patients and their families to improve their quality of life and make more efficient use of health services. The nurse assesses patient needs, monitors conditions, educates and empowers the patient, and works with community agencies to ensure that the patient’s healthcare goals are met.

**health benefit plan.** Any public or private organization’s written plan that insures or pays for specific health or medical expenses on behalf of enrollees and/or covered persons.

**Health Care Financing Administration (HCFA).** An administrative body of the federal government that oversees all aspects of health financing.

**health insurance.** Protection that provides payment of benefits for covered sickness or injury; includes various types of insurance, such as accident protection, disability income, medical expenses, and accidental death and dismemberment coverage.

**Health literacy.** The ability to understand health information and to use that information to make good decisions about your health and medical care.

**health maintenance organization (HMO).** An organization that provides health care for a geographic area and that accepts responsibility for delivering an agreed-upon set of health maintenance and treatment services to a voluntarily enrolled group. An HMO collects a predetermined periodic payment paid in advance on behalf of each individual enrolled.
holistic medicine. A trend in medicine that emphasizes that the system must extend its focus beyond the physical aspects of disease or particular organs. It is concerned with the whole person and the interrelationships between the emotional, social, spiritual, and physical implications of disease and health.

home health care. Health care provided in the home to aged, disabled, sick, or convalescent individuals who do not need institutional care. The most common types of home care include visiting nurse services and speech, physical, occupational, and rehabilitation therapy. These services are provided by home health agencies, hospitals, or other community organizations.

home health services. Health care services provided to a patient in his or her own home by health care personnel.

hospice. A health care program whose purpose is to provide care, compassion, and support for those patients in the final stages of illness and close to death.

hospital alliances. Groups of hospitals allied together to reduce costs by sharing common services and developing group purchasing programs.

impairment. An inability or lessened ability to perform work duties because of a work-related injury or disease.

indemnity. The security against possible loss or damage; a predetermined reimbursement amount paid in the event of a covered loss.

independent medical exam (IME). A medical exam used by insurers to determine an individual’s diagnosis, need for continued treatment, degree and permanency of disability, or ability to return to work.

independent practice association (IPA). An HMO that contracts with physicians who see HMO patients in their own private offices. Physicians are reimbursed on a capitated or a fee-for-service basis.

initial evaluation. The assessment conducted by a case manager following case referral. Medical, psychological, social, vocational, educational, and economic factors are explored to ascertain the best course of action for achieving rehabilitation and the feasibility of rehabilitation.

injury. Harm to a worker that requires treatment and/or compensation under workers’ compensation.
inside limits. Internal control limits within the structure of overall benefits or the benefit plan; they are utilized to establish a maximum amount for a procedure, service, confinement, disability, calendar year, and so on.

job description. A detailed description of the duties, tasks, and requirements of a job, including specific physical and mental qualifications for performance. A job description is an important tool for analyzing an insured’s potential to return to his or her pre-injury job and for ascertaining transferable skills.

legal reserve. The minimum reserve a company must keep to meet future claims and obligations as calculated under a state insurance code.

long-term care. The health care provided to individuals who do not require hospital care but who do need nursing, medical, and other health care services provided over time.

long-term disability income insurance. The insurance issued to a group or an individual to provide a reasonable replacement of a portion of income lost due to a serious, prolonged illness.

loss control. The efforts by insurers and insureds to prevent accidents and reduce losses through the maintenance and upgrading of health and safety procedures.

loss expenses. The part of an expense (such as legal allocation fees) paid by an insurance company directly to the plaintiff in settling a particular claim.

loss-of-time benefits. The benefits paid to help replace earned income lost through inability to work because of a disability caused by accident or illness. Weekly indemnity insurance is the type of insurance that provides such benefits.

loss ratio. The ratio of losses to premiums for a given period.

loss reserve. The dollar amount designated as the estimated cost of an accident at the time the first notice is received.

malingering. The practice of feigning illness or inability to work in order to collect insurance benefits.

malpractice. Improper care or treatment by a physician.

managed care. A system of health care delivery aimed at managing the cost and quality of access to health care. Managed care is used by
HMOs, PPOs, and managed indemnity plans to improve the delivery of services and contain costs.

**maximum benefit (overall maximum benefit)**. The maximum amount any one individual may receive under an insurance contract.

**Medicaid**. The state public assistance programs open to persons of any age whose financial resources are insufficient to pay for health care. Provided under Title XIX of the Social Security Act of 1986.

**Medical Home**. The medical home is a concept or model of care delivery that includes an ongoing relationship between a provider and patient, around the clock access to medical consultation, respect for the patient/family’s cultural and religious beliefs, and a comprehensive approach to care and coordination of care through providers and community services.

**Medicare**. The hospital insurance and supplementary medical insurance systems for the aged and disabled created in 1965 by amendments to the Social Security Act.

**modified job**. The predisability job adapted for the insured in such a manner that it can be performed within prescribed physical or mental limitations.

**modified open panel plan**. A service approach to the provision of group legal insurance in which any lawyer who agrees to accept a predetermined fee schedule and other procedural requirements may provide covered legal services to a member of a plan.

**network model HMO**. An independent practice association of group practices as opposed to solo physicians.

**nondisabling injury**. An injury that may require medical care but does not result in loss of working time or income.

**nonduplication clause**. A clause that excludes expenses incurred to the extent that an employee or dependent receives benefits under any type of policyholder-sponsored insurance plan.

**nonexempt (nonexempt employees)**. A classification of employees designating those employees subject to overtime compensation and working time limits under the federal Labor Standards Act.

**nonoccupational insurance**. Insurance that does not provide benefits for an accident or sickness arising out of a person's employment.
occupancy rate. A measure of inpatient health facility use determined by dividing available bed days by patient days. It measures the average percentage of a hospital’s beds occupied and may be institutionwide or limited to one department or service.

occupational therapy (OT). A program of prescribed activities that focuses on coordination and mastery and is designed to assist the insured to regain independence, particularly in activities of daily living.

orthotics. The field that specializes in using orthopedic appliances, braces, and other devices to support weight, prevent or correct deformities, or improve the function of movable parts of the body.

overinsurance. Insurance exceeding in amount the probable loss to which it applies. Overinsurance, which can be a serious problem, is controlled in group medical care coverage by the contractual use of nonduplication of benefits provisions (e.g., coordination of benefits).

partial disability. A condition resulting from an illness or injury that prevents an insured from performing one or more regular job functions.

per diem cost. Literally, cost per day. Refers, in general, to hospital or other inpatient institutional costs for a day of care. Hospitals occasionally charge for their services using a per diem rate derived by dividing total costs by the number of inpatient days of care given. Per diem costs are, therefore, averages and do not reflect the true cost for each patient. Thus, the per diem approach is said to give hospitals an incentive to prolong hospital stays.

period of disability. The period during which an employee is prevented from performing the usual duties of his or her occupation or employment or during which a dependent is prevented from performing the normal activities of a healthy person of the same age and sex. More than one cause (accident or sickness) may be present during or contribute to a single period of disability.

permanent and total disability. A disability that will presumably last for the insured’s lifetime and that prevents him or her from engaging in any occupation for which he or she is reasonably fitted.

physician advisor. A physician who represents a claims administrator or utilization review organization and who provides advice on whether to certify an admission, extension of stay, or other medical service as being medically necessary and appropriate.
point-of-service (POS) plan. Evolved from the preferred provider organization concept, point-of-service plans are customized managed care plans often offered by larger companies. These plans combine employee choice and customized care with tight medical management and local utilization.

preadmission authorization (or precertification). The practice of requiring those covered by a health care plan to telephone a claims department prior to hospitalization, outpatient surgery, or other significant medical procedure. In most cases, a two-week notification period is requested, with allowances made for emergency treatment, for which a report within 48 hours of hospital admission is generally required.

preexisting condition. A physical or mental condition of an insured that manifested itself prior to the issuance of the individual policy or for which treatment was received prior to such issuance.

preferred provider organization (PPO). A system of health care delivery in which a third-party payer contracts with a group of medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients. The discounted fee structure is usually of a fee-for-service type.

preventative care. Care directed at preventing disease or its consequences (e.g., through immunization and early detection). Promotion of health through improving the environment or altering behaviors, especially through health education, has gained prominence and is an important strategy used, for example, by HMOs, primary care centers, and others.

primary care. Basic health care provided by physicians, general practitioners, internists, obstetricians, pediatricians, and midlevel practitioners that emphasizes a patient’s general health needs as opposed to specialized care. Includes basic or initial diagnosis and treatment, health supervision, management of chronic conditions, and preventative health services. Appropriate referral to consultants and community resources is an important facet of primary care.

probationary period. The length of time a person must wait from the day of his or her entry into an eligible class or application for coverage to the date his or her insurance becomes effective. Also sometimes referred to as the service period or waiting period.

profile. A longitudinal or cross-sectional aggregation of medical care data. A patient profile lists all of the services provided to a particular
patient during a specified period of time. Physician, hospital, or population profiles are statistical summaries of the pattern of practice of individual physicians or hospitals or the medical experience of specific populations. Diagnostic profiles, a subcategory of physician, hospital, or population profiles, focus on a specific condition or diagnosis.

**proposal.** A quotation submitted to a prospective group insurance policyholder by the insurance company through an agent, broker, or group representative. This quotation outlines the benefits available under the proposed plan and the costs to both employer and employee. This is an important visual sales aid.

**protocols.** The generally accepted procedures and methods for the delivery of medical care.

**provider.** A licensed health care facility, physician, or other health care professional that delivers health care services.

**rate.** The charge per unit of payroll used to determine workers’ compensation or other insurance premiums. The rate varies according to the risk classification of the policyholder.

**rating.** The application of the proper classification rate and other factors that may be used to set the premium rate for a policyholder. The three principal forms are manual, experience, and retrospective rating.

**reconsideration.** An initial request for additional review of a utilization review organization’s determination not to certify an admission, extension of stay, or other medical service. A reconsideration request is called an *expedited appeal* by some utilization review organizations.

**rehabilitation.** The restoration of a totally disabled person to a meaningful occupation. A provision in some long-term disability policies provides for a continuation of benefits or other financial assistance while a totally disabled insured is being retrained or attempting to resume productive employment.

**reinsurance carriers.** Insurers for the insurers. See stop-loss insurance.

**reserve general.** (1) An amount representing actual or potential liabilities that is kept by an insurer to cover debts to policyholders; (2) an amount allocated for a special purpose. Note that a reserve is usually a liability and not an extra fund. On occasion, a reserve may be an asset, such as a reserve for taxes not yet due.
retrospective review. Another form of utilization review that allows insurers and employers to maintain records of physicians’ practice patterns, hospital length of stay averages, and typical treatment patterns for specific diagnoses and thereby build a database to help analyze “standard and reasonable” procedures and costs.

review criteria. The written policies, decision rules, medical protocols, or guides used by a utilization review organization to determine certification (e.g., appropriateness evaluation protocols [AEPs] and intensity of service, severity of illness, discharge and appropriateness [ISD-A] screens).

second surgical opinion (SSO). When there is a complex medical picture, when questionable treatment is under way, or when elective surgery is recommended, a second surgical opinion is often requested by the insurer, employer, or patient. Some of the elective surgeries leading to an SSO request are often unnecessary, such as the removal of adenoids, bunions, gallbladder, and tonsils or open-heart, knee, or hip surgery.

settlement options. The provisions (stated or intended) in insurance contracts that allow an insured or beneficiary to receive benefits in other than a lump sum payment.

short-term disability income insurance. The insurance that pays benefits during the time a disability exists to a covered person who remains disabled for a specified period not to exceed 2 years.

staff model HMO. An HMO that employs physicians who operate out of their own facilities or clinics but who receive a salary from the HMO.

stop-loss insurance. The insurance taken by employer groups to cover the financial responsibility of health benefit payments that exceed an established threshold. A company might have health care benefits of $1,000,000 per covered life, with a threshold set at $100,000 with a reinsurer. This means there is coverage for a patient with claims of $150,000 or $250,000, but the company only pays the first $100,000 out of its group coverage and is reimbursed dollar for dollar by the stop-loss carrier for any costs over the threshold up to $1,000,000.

subrogation. In the health insurance context, subrogation is the contractual right of the plan or carrier, where state law permits, to succeed to the rights of the covered person in relation to a claim against a third party. This means that the insured party gives up the right to sue the negligent party. This right is given to the insurance company because it has paid a claim on the insured’s behalf. If the insured suffers damages
over and above those covered by his or her policy, he or she can sue the third party.

**targeted review.** A review process that focuses on specific diagnoses, services, hospitals, or practitioners rather than on all services provided or proposed to be provided to enrollees.

**third-party administration.** The administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

**Third Party Administrator (TPA).** The companies that work with insurance firms, handling all the administrative tasks involved in processing claims. Employers who have become self-insurers, taking on the responsibility of funding their own benefit plans, may use a TPA or they may oversee the payment of claims themselves, via a self-insured, self-administered plan.

**third-party payment.** The payment of health care by an insurance company or other organization so that the patient does not directly pay for his or her services.

**transferable skills.** The skills an insured has acquired through occupational or vocational endeavors that may be applied with minimal training in another occupation.

**usual, customary, and reasonable (UCR).** Health insurance plans often pay a physician’s full charge if it does not exceed his or her usual charge, if it does not exceed the amount customarily charged for the service by other physicians in the area, or if it is otherwise reasonable.

**utilization.** Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service (hospital care, prescription drugs, physician visits). Measurement of utilization of all medical services in combination is usually done in terms of dollar expenditures. Use is expressed in rates per unit of population at risk for a given period (e.g., number of admissions to a hospital per 1,000 persons over 65 years of age per year).

**utilization review (UR).** The process of reviewing medical services for necessity, appropriateness, and efficiency to ensure that a patient is not given care that exceeds medical need and, thereby, reduces the number of unnecessary or inappropriate health care services. It includes review of admissions, length of stay, discharge, and services ordered and provided and is conducted on a preadmission, concurrent, and retrospective basis.
utilization review organization. An entity that conducts utilization review and determines certification of an admission, extension of stay, or other medical service.

vocational evaluation. A professional analysis of the insured’s work potential, integrating information about physical capabilities, mental aptitudes, interests, personality motivation, transferable skills, and environmental considerations.

workers’ compensation. The social insurance system for industrial and work injuries regulated in certain specified occupations by the federal government.

workers’ compensation law. A statute imposing liability on employers to pay benefits and furnish care to employees injured and to pay benefits to dependents of employees killed in the course of and because of their employment.

LEGAL TERMINOLOGY

agency. A relationship between two parties in which the first party authorizes the second to act as agent on behalf of the first. It usually implies a contractual arrangement between two parties managed by a third party, an agent.

agent. A party authorized to act on behalf of another and to give the other an account of such actions.

appeal. The process whereby a court of appeals reviews the record of written materials from a court proceeding to determine if errors were made that might lead to a reversal of the trial court’s decision.

assumption of risk. A doctrine based on voluntary exposure to a known risk. It is distinguished from contributory negligence (which is based on carelessness) in that it involves the comprehension that a peril is to be encountered as well as the willingness to encounter it.

claimant. One who asserts a right or demand in a legal proceeding.

claims-made policy. A professional liability insurance policy that covers the holder for a period in which a claim of malpractice is made. The alleged act of malpractice may have occurred at some previous time but the policy insures the holder when the claim is made.
compensation. An act that a court orders (including money that a court or other tribunal orders to be paid) by a person whose acts or omissions have caused loss or injury in order to recompense the injured party with respect to the loss.

confidential communications. Certain classes of communications that the law will not permit to be divulged; in general, such communications pass between persons who stand in a confidential or fiduciary relationship to each other (or who, because of their relative situation, owe a special duty of secrecy and fidelity).

cross-examination. The questioning of a witness during a trial or deposition by the party opposing those who asked the person to testify.

damages. The money awarded by the court to someone who has been injured (plaintiff) that must be paid by the party responsible for the injury (defendant). Normal damages are awarded when the injury is considered to be slight. Compensatory damages are awarded to repay or compensate the injured party for the loss that was incurred. Punitive damages are awarded when the injury is found to have been committed maliciously or in wanton disregard of the plaintiff’s interests.

defendant. The person against whom an action is brought because of an alleged responsibility for violating one or more of the plaintiff’s legally protected interests.

deposition. A sworn pretrial testimony given by a witness in response to oral and written questions and cross-examination. The deposition is transcribed and may be used for further pretrial investigation. It may also be presented at the trial if the witness cannot be present.

disability. In a legal context, the term means incapacity for the full enjoyment of ordinary legal rights.

discovery. A pretrial procedure that allows the plaintiff’s and defendant’s attorneys to find out about matters relevant to the case, including information about what evidence the other side has, what witnesses will be called, and so on. Discovery devices for obtaining information include depositions and interrogatories to obtain testimony, requests for documents and other tangible evidence, and requests for physical or mental examinations.
evidence. Any species of proof or probative matter, legally presented at
the trial of an issue, by the act of the parties and through the medium
of witnesses, records, documents, tangible objects, and the like, for the
purpose of inducing beliefs in the minds of the court or jury as to the
truth of their contention.

expert witness. A person who has special knowledge of a subject about
which a court requests testimony. Special knowledge may be acquired
by experience, education, observation, or study but is not possessed by
the average person. An expert witness gives expert testimony or expert
evidence. This evidence often serves to educate the court and the jury
in the subject under consideration.

fiduciary relationship. A legal relationship of confidentiality that exists
whenever one person trusts or relies on another, such as a doctor–
patient relationship.

fraud. A false representation of a matter of fact (whether by words or
conduct, by false or misleading allegations, or by concealment of that
which should be disclosed) that deceives and is intended to deceive
another so that person shall act upon such representation to his or her
legal injury.

guardian ad litem. A person appointed by the court to safeguard a
minor’s legal interest during certain kinds of litigation.

imputed negligence. Malpractice due to negligent practice of a person
taught.

in loco parentis. The Latin phrase meaning “in the place of the parent.”
The assumption by a person or institution of the parental obligations of
caring for a child without adoption.

indemnify. To secure against loss or damage; to give security for the
reimbursement of a person in the event of an anticipated loss to that
individual.

injury. Any wrong or damage done to another, either to the individual’s
person, rights, reputation, or property. Consists of damages of a per-
manent nature.

interrogatories. A series of written questions submitted to a witness or
other person having information of interest to the court. The answers
are transcribed and are sworn to under oath.
liability. The legal responsibility for failure to act, thus causing harm to another person, or for actions that fail to meet standards of care, so causing another person harm.

liaison. A nurse who acts as an agent between a patient, the hospital, and the patient’s family and who speaks for the entire health care team.

litigation. A contest in a court for the purpose of enforcing a right.

malfeasance. The performance of an unlawful, wrongful act.

malpractice. A professional person’s wrongful conduct, improper discharge of professional duties, or failure to meet standards of care, which results in harm to another person.

misfeasance. An improper performance of a lawful act, especially in a way that might cause damage or injury.

motion. A request to the court to take some action or a request to the opposing side to take some action relating to a case.

negligence. The failure to act as an ordinary prudent person; conduct contrary to that of a reasonable person under similar circumstances.

nonfeasance. A failure to perform a task, duty, or undertaking that one has agreed to perform or that one had a legal duty to perform.

petition. An ex parte application to a court asking for the exercise of the court’s judicial powers in relation to some matter that is not the subject for a suit or action, or a request for the authority to undertake an action that requires the sanction of the court.

plaintiff. A person who brings a suit to court in the belief that one or more of that individual’s rights have been violated or that a legal injury has occurred.

professional corporation (PC). A corporation formed according to the law of a particular state for the purpose of delivering a professional service.

professional liability. A legal concept describing the obligation of a professional person to pay a patient or client for damages caused by the professional’s act of omission, commission, or negligence. Professional liability better describes the responsibility of all professionals to their clients than does the concept of malpractice, but the idea of professional liability is central to malpractice.


**Appendix B**

**Professional liability insurance.** A type of liability insurance that protects professional persons against malpractice claims made against them.

**Release.** The relinquishment of a right, claim, or privilege by a person in whom it exists or to whom it accrues, to the person against whom it might be demanded or enforced.

**Remedy.** The means by which a right is enforced or the violation of a right is prevented, redressed, or compensated.

**Res ipsa loquitur.** Literally, “the thing speaks for itself.” A legal doctrine that applies when the defendant was solely and exclusively in control at the time the plaintiff’s injury occurred, so that the injury would not have occurred if the defendant had exercised due care. When a court applies this doctrine to a case, the defendant bears the burden of proving that he was not negligent.

**Respondeat superior.** Literally, “let the master respond.” This maxim means that an employer is liable in certain cases for the consequences of the wrongful acts of its employees while the employee is acting within the scope of his or her employment.

**Right of conscience law.** A legal equivalent to freedom of thought or of religion.

**Right of privacy.** The right of individuals to withhold their person and property from public scrutiny, if so desired, as long as it is consistent with the law of public policy.

**Right to access law.** A law that grants a patient the right to see his or her medical records.

**Right to die law.** A law that upholds a patient’s right to choose death by refusing extraordinary treatment when the patient has no hope of recovery. Also referred to as the natural death law or living will law.

**Settlement.** An agreement by the parties to a transaction or controversy that resolves some or all of the issues involved in a case.

**Standards of care.** In a malpractice lawsuit, those acts performed or omitted that an ordinary, prudent person in the defendant’s position would have done or not done, a measure by which the defendant’s alleged wrongful conduct is compared.

**Statute.** The written act of a legislative body declaring, commanding, or prohibiting an action (in contrast to unwritten common law).
**Appendix B**

**statute of limitations.** A statute that sets forth limitations of the right of action for certain described causes (e.g., declaring that no suit can be maintained on such cases of action unless brought within a specified period of time after the right came into existence).

**subpoena.** A process commanding a witness to appear and give testimony in court.

**tort.** A private or civil wrong outside of a contractual relationship.

**tort-feasor.** A wrongdoer who is legally liable for the damage caused.

**uniform anatomical gift act.** A law of the type existing in all 50 states that allows anyone over 18 to sign a donor card willing some or all of his or her organs after death.

**waiver.** The intentional or voluntary relinquishment of a known right.

**wrongful death statute.** A statute of the type existing in all states that provides that the death of a person can give rise to a cause of legal action brought by the person’s beneficiaries in a civil suit against the person whose willful or negligent acts caused the death. Prior to the existence of these statutes, a suit could be brought only if the injured person survived the injury.

**wrongful life action.** A civil suit usually brought against a physician or health facility on the basis of negligence that resulted in the wrongful birth or life of an infant. The parents of the unwanted child seek to obtain payment from the defendant for the medical expenses of pregnancy and delivery, for pain and suffering, and for the education and upbringing of the child. Wrongful life actions have been brought and won in several situations, including malpracticed tubal ligations, vasectomies, and abortions. Failure to diagnose pregnancy in time for abortion and incorrect medical advice leading to the birth of a defective child have also led to malpractice suits for a wrongful life.

**ACRONYMS AND ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; H</td>
<td>accident and health</td>
</tr>
<tr>
<td>A &amp; S</td>
<td>accident and sickness</td>
</tr>
<tr>
<td>AAOHN</td>
<td>American Association of Occupational Health Nurses</td>
</tr>
<tr>
<td>ABOHN</td>
<td>American Board for Occupational Health Nurses</td>
</tr>
<tr>
<td>A-CCC</td>
<td>Continuity of Care Certification, Advanced</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>ACCM</td>
<td>Academy for Certified Case Managers</td>
</tr>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act of 1990</td>
</tr>
<tr>
<td>ADB</td>
<td>accelerated death benefit</td>
</tr>
<tr>
<td>ADEA</td>
<td>Age Discrimination in Employment Act</td>
</tr>
<tr>
<td>ADL</td>
<td>activities of daily living</td>
</tr>
<tr>
<td>AEP</td>
<td>appropriateness evaluation protocol</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>ANA</td>
<td>American Nurses Association</td>
</tr>
<tr>
<td>ANYOCC</td>
<td>any occupation (used in long-term disability policies)</td>
</tr>
<tr>
<td>ASO</td>
<td>administrative services only</td>
</tr>
<tr>
<td>CAM</td>
<td>complementary and alternative medicine</td>
</tr>
<tr>
<td>CARF</td>
<td>Commission on Accreditation of Rehabilitation Facilities</td>
</tr>
<tr>
<td>CAT</td>
<td>computerized axial tomography</td>
</tr>
<tr>
<td>CCM</td>
<td>Certified Case Manager</td>
</tr>
<tr>
<td>CCMC</td>
<td>Commission for Case Management</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control</td>
</tr>
<tr>
<td>CDH</td>
<td>consumer-driven health care</td>
</tr>
<tr>
<td>CDMS</td>
<td>Certified Disability Management Specialist</td>
</tr>
<tr>
<td>CDMSC</td>
<td>Certification of Disability Management Specialists Commission</td>
</tr>
<tr>
<td>CIRS</td>
<td>Certified Insurance Rehabilitation Specialist</td>
</tr>
<tr>
<td>CIRSC</td>
<td>Certification of Insurance Rehabilitation Specialists Commission</td>
</tr>
<tr>
<td>CLAS</td>
<td>National Standards on Culturally and Linguistically Appropriate Service in Health Care</td>
</tr>
<tr>
<td>CM</td>
<td>Case Manager</td>
</tr>
<tr>
<td>CMAC</td>
<td>Case Management Administrator, Certified</td>
</tr>
<tr>
<td>CMC</td>
<td>Case Manager Certified (from NACCM)</td>
</tr>
<tr>
<td>CMC</td>
<td>Case Manager, Certified (from AIOCM)</td>
</tr>
<tr>
<td>CMC-A</td>
<td>Case Manager Associate</td>
</tr>
<tr>
<td>CMCN</td>
<td>Certified Managed Care Nurse</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services (formerly HCFA, Health Care Financing Administration)</td>
</tr>
<tr>
<td>CMSA</td>
<td>Case Management Society of America</td>
</tr>
<tr>
<td>COB</td>
<td>coordination of benefits</td>
</tr>
<tr>
<td>COBRA</td>
<td>Consolidated Omnibus Budget Reconciliation Act of 1986</td>
</tr>
<tr>
<td>COHN</td>
<td>Certified Occupational Health Nurse</td>
</tr>
<tr>
<td>COHN/CM</td>
<td>Certified Occupational Health Nurse/Case Manager</td>
</tr>
<tr>
<td>COHN-S</td>
<td>Certified Occupational Health Nurse-Specialist</td>
</tr>
</tbody>
</table>
Appendix B

COHN-S/CM  Certified Occupational Health Nurse-Specialist/Case Manager
CPHQ   Certified Professional in Health Care Quality
CPT    Current Procedural Terminology (used in code designations)
CRC    Certified Rehabilitation Counselor
CRRN   Certified Rehabilitation Registered Nurse
C-SWCM Certified Social Worker Case Manager
DME    durable medical equipment
DRG    diagnosis-related group
EPO    exclusive provider organization
ERISA  Employee Retirement Income Security Act of 1974
FDA    Federal Drug Administration
FMLA   Family and Medical Leave Act of 1993
FRER   Foundation for Rehabilitation Certification Education & Research
HBV    Hepatitis B virus
HCFA   Health Care Financing Administration (now CMS, Centers for Medicare and Medicaid Services)
HCO    health care organization
HEDIS  Health Plan Employer Data and Information Set
HHA    home health agency
HHC    home health care
HIA    health insurance alliance
HIPAA  Health Insurance Portability and Accountability Act of 1996 (also called the Kassebaum-Kennedy Act)
HIPCs  health insurance purchasing cooperatives
HISOCC his occupation (used in long-term disability policies)
HIV    human immunodeficiency virus
HMO    health maintenance organization
ICD-9  International Classification of Disease, 9th edition
IDFN   integrated delivery and financing network (an IDS)
idfs   integrated delivery and financing system (an IDS)
idn    integrated delivery network (an IDS)
IDS    integrated delivery system
IOM    Institute of Medicine
IPA    independent practice arrangement
ISD-A  intensity of service, severity of illness, discharge and appropriateness
JCAHO  Joint Commission on Accreditation of Healthcare Organizations
LPN    Licensed Practical Nurse
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTD</td>
<td>long-term disability</td>
</tr>
<tr>
<td>LVN</td>
<td>Licensed Vocational Nurse</td>
</tr>
<tr>
<td>MCO</td>
<td>managed care organization</td>
</tr>
<tr>
<td>MSA</td>
<td>Medical Savings Account</td>
</tr>
<tr>
<td>MSO</td>
<td>managed services organization</td>
</tr>
<tr>
<td>OMH</td>
<td>Office of Minority Health</td>
</tr>
<tr>
<td>OT</td>
<td>occupational therapist or occupational therapy</td>
</tr>
<tr>
<td>PBM</td>
<td>pharmacy benefits management</td>
</tr>
<tr>
<td>PCP</td>
<td>primary care physician</td>
</tr>
<tr>
<td>PHO</td>
<td>physician–hospital organization</td>
</tr>
<tr>
<td>PhRMA</td>
<td>Pharmaceutical Research and Manufacturers of America</td>
</tr>
<tr>
<td>PIP</td>
<td>personal injury protection (auto policy clause)</td>
</tr>
<tr>
<td>POS</td>
<td>point-of-service</td>
</tr>
<tr>
<td>PPO</td>
<td>preferred provider organization</td>
</tr>
<tr>
<td>PPS</td>
<td>prospective payment system</td>
</tr>
<tr>
<td>PRO</td>
<td>professional review organization</td>
</tr>
<tr>
<td>PSDA</td>
<td>The Patient Self-Determination Act</td>
</tr>
<tr>
<td>PSRO</td>
<td>professional standards review organization</td>
</tr>
<tr>
<td>PT</td>
<td>physical therapist or physical therapy</td>
</tr>
<tr>
<td>R &amp; C</td>
<td>reasonable and customary</td>
</tr>
<tr>
<td>RN-NCM</td>
<td>Registered Nurse-Nurse Case Manager</td>
</tr>
<tr>
<td>SNF</td>
<td>skilled nursing facility</td>
</tr>
<tr>
<td>SNV</td>
<td>skilled nursing visit</td>
</tr>
<tr>
<td>SHMOs</td>
<td>social health maintenance organizations</td>
</tr>
<tr>
<td>SPD</td>
<td>summary plan description</td>
</tr>
<tr>
<td>STD</td>
<td>short-term disability</td>
</tr>
<tr>
<td>TEFRA</td>
<td>Tax Equity and Fiscal Responsibility Act of 1982</td>
</tr>
<tr>
<td>TPA</td>
<td>Third Party Administrator</td>
</tr>
<tr>
<td>TPN</td>
<td>total parenteral nutrition</td>
</tr>
<tr>
<td>URAC</td>
<td>Utilization Review Accreditation Commission, also doing business as the American Accreditation HealthCare Commission</td>
</tr>
<tr>
<td>WC</td>
<td>workers’ compensation</td>
</tr>
</tbody>
</table>

The glossary includes terms adapted or reprinted from *A thru Z: Managed Care Terms*, with permission of Medicom International and Novartis, © 2001; *Managed Healthcare*, with permission of Logical Health Care Solutions Corporation, © 2000; *Managed Care: What It Is and How It Works*, second edition, by Peter R. Kongstvedt, with permission of Jones and Bartlett Publishers, Inc., © 2004; *Home Care: An Emerging Solution to the Nation’s Health Care Crisis*, with permission of Olsten.
Appendix B

Kimberly QualityCare, © 1993; CCM Certification Guide, with permission of the Foundation for Rehabilitation Certification, Education and Research, © 1993;