

Healthcare Regulations and Compliance

Healthcare Regulations and Compliance Glossary

A

1. **Accountable Care Organization (ACO):** An organization of healthcare providers that voluntarily come together to coordinate care for Medicare patients. ACOs are accountable for the quality, cost, and overall care of assigned patients.
2. **Administrative Simplification:** The provisions within the Health Insurance Portability and Accountability Act (HIPAA) that aim to streamline administrative processes within the healthcare industry, such as electronic transactions, code sets, and identifiers.
3. **Advance Beneficiary Notice (ABN):** A notice given to Medicare beneficiaries by providers, physicians, or suppliers when they believe that Medicare will not cover a specific service.
4. **Affordable Care Act (ACA):** Legislation passed in 2010 that aimed to increase access to healthcare insurance, lower costs, and improve quality of care for Americans. The ACA introduced various regulations impacting healthcare providers and payers.

B

5. **Balanced Budget Act of 1997:** Legislation that made significant changes to Medicare and Medicaid programs, including establishing the Children's Health Insurance Program (CHIP) and implementing payment reforms.
6. **Beneficiary Inducements:** Prohibitions on offering or receiving remuneration to influence patient care decisions, as outlined in the federal Anti-Kickback Statute and the Civil Monetary Penalties Law.

C

7. **Certification:** The process by which a healthcare organization or provider demonstrates compliance with specific standards set by accrediting bodies or regulatory agencies.
8. **Civil Monetary Penalties Law (CMPL):** Legislation that imposes penalties on healthcare providers for various violations, such as submitting false claims, kickbacks, and noncompliance with federal healthcare program requirements.
9. **Compliance Program:** A formal set of policies, procedures, and processes established by healthcare organizations to ensure adherence to regulatory requirements, reduce fraud and abuse, and promote ethical behavior.

10. Conditions of Participation (CoPs): The standards that healthcare providers must meet to participate in the Medicare and Medicaid programs, ensuring quality of care and patient safety.

11. Consent Decree: A legal agreement between a healthcare entity and a regulatory agency to resolve compliance issues without admitting guilt, often involving fines, corrective action plans, and ongoing monitoring.

12. Corporate Integrity Agreement (CIA): An agreement between a healthcare organization and the Office of Inspector General (OIG) to address compliance deficiencies, typically involving ongoing monitoring, reporting, and oversight.

D

13. Data Breach: Unauthorized access, disclosure, or acquisition of protected health information (PHI) that compromises the security or privacy of individuals, requiring notification to affected parties and regulatory authorities.

14. Deficit Reduction Act of 2005: Legislation that expanded anti-fraud provisions, including the requirement for healthcare providers to establish compliance programs and report overpayments to government payers.

15. Drug Enforcement Administration (DEA): A federal agency responsible for enforcing controlled substances laws and regulations, overseeing the prescribing and dispensing of medications with abuse potential.

E

16. Electronic Health Record (EHR): A digital version of a patient's paper chart, containing medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory test results.

17. Emergency Medical Treatment and Labor Act (EMTALA): Legislation that requires hospitals to provide emergency medical treatment to individuals regardless of their ability to pay or insurance status, preventing patient dumping.

F

18. Fraud: Intentional deception or misrepresentation that results in an unauthorized benefit, such as false billing, kickbacks, upcoding, and unbundling, leading to financial loss for government payers and patients.

19. Federal Register: The official journal of the federal government of the United States that contains proposed rules, final rules, notices, and presidential documents related to healthcare regulations and compliance.

G

20. Good Manufacturing Practices (GMP): Regulations established by the Food and Drug Administration (FDA) to ensure the quality, safety, and efficacy of pharmaceuticals, medical devices, and biologics through manufacturing standards.

H

21. Health Information Technology for Economic and Clinical Health (HITECH) Act: Legislation that promotes the adoption and meaningful use of electronic health records (EHRs) and strengthens privacy and security protections for health information.

22. Health Insurance Portability and Accountability Act (HIPAA): Legislation that protects the privacy and security of individuals' health information, establishes national standards for electronic healthcare transactions, and addresses fraud and abuse in healthcare.

23. Health Maintenance Organization (HMO): A type of managed care organization that provides healthcare services through a network of providers for a fixed prepaid fee, requiring members to select a primary care physician and obtain referrals for specialists.

24. Health Resources and Services Administration (HRSA): An agency of the U.S. Department of Health and Human Services (HHS) that oversees programs addressing healthcare access, quality, and workforce shortages, particularly in underserved communities.

25. Healthcare Fraud: The intentional deception or misrepresentation by individuals or entities for financial gain, including false claims, kickbacks, billing for unnecessary services, and identity theft.

26. Healthcare Regulatory Agencies: Federal and state entities responsible for enforcing laws and regulations that govern healthcare delivery, reimbursement, quality, safety, privacy, and compliance, such as the Centers for Medicare & Medicaid Services (CMS).

27. Healthcare Compliance Officer: An individual within a healthcare organization responsible for overseeing compliance with laws, regulations, policies, and ethical standards, developing compliance programs, conducting audits, and addressing violations.

28. Healthcare Provider: An individual or organization that delivers medical services, including physicians, nurses, hospitals, clinics, pharmacies, laboratories, and other entities involved in patient care.

29. Healthcare Regulation: Laws, rules, and guidelines that govern the operation, licensure, accreditation, reimbursement, quality, safety, privacy, and compliance of healthcare providers, payers, and suppliers.

30. Healthcare Compliance: The process of adhering to laws, regulations, policies, and ethical standards in the delivery of healthcare services, ensuring patient safety, quality of care, data privacy, financial integrity, and ethical conduct.

31. Healthcare Compliance Program: A structured approach to promoting and monitoring compliance with laws, regulations, policies, and ethical standards within a healthcare organization, encompassing risk assessment, training, auditing, reporting, and corrective action.

32. **Healthcare Licensing:** The process by which healthcare providers and facilities obtain permission from regulatory authorities to operate and deliver services, ensuring compliance with standards for qualifications, staffing, equipment, and safety.

33. **Healthcare Accreditation:** The voluntary process by which healthcare organizations undergo external review to demonstrate compliance with established standards for quality, safety, patient care, and organizational performance.

34. **Healthcare Compliance Training:** Educational programs and resources provided to healthcare professionals, employees, and stakeholders to increase awareness of compliance requirements, promote ethical behavior, and reduce the risk of violations.

I

35. **Individualized Education Program (IEP):** A written plan developed for students with disabilities that outlines their educational goals, services, accommodations, and modifications to support their learning needs and ensure academic progress.

36. **Internal Revenue Service (IRS):** A federal agency responsible for collecting taxes and enforcing tax laws, including regulations related to healthcare tax exemptions, deductions, credits, and reporting requirements.

J

37. **Joint Commission:** An independent, nonprofit organization that accredits and certifies healthcare organizations and programs based on quality and safety standards, promoting continuous improvement in patient care.

K

38. **Kickbacks:** Illegal payments or remuneration exchanged for patient referrals, services, or products, violating anti-kickback laws and regulations that aim to prevent fraud, abuse, and conflicts of interest in healthcare.

L

39. **Licensure:** The process by which healthcare professionals obtain a license from a state regulatory board to practice their profession, demonstrating competency, qualifications, and compliance with regulatory standards.

40. **Long-Term Care (LTC):** Services provided to individuals who require assistance with activities of daily living, medical care, and support over an extended period, often in nursing homes, assisted living facilities, or home settings.

M

41. **Medicaid:** A joint federal and state program that provides health coverage to low-income individuals,

pregnant women, children, elderly, and people with disabilities, offering a range of benefits and services based on eligibility criteria.

42. Medicare: A federal health insurance program for individuals aged 65 and older, certain younger people with disabilities, and individuals with end-stage renal disease, covering hospital stays, physician services, prescription drugs, and other healthcare needs.

43. Medicare Advantage: A type of Medicare health plan offered by private companies that contract with Medicare to provide Part A and Part B benefits, often including additional services like prescription drug coverage and wellness programs.

44. Medicare Part D: A prescription drug benefit program offered to Medicare beneficiaries through private insurance plans, providing coverage for medications at retail pharmacies or through mail order services.

45. Medicare Fraud: The intentional submission of false claims, kickbacks, and other deceptive practices that defraud the Medicare program, resulting in financial losses, penalties, and legal consequences for healthcare providers and suppliers.

46. Medical Necessity: The requirement that healthcare services and treatments be reasonable, necessary, and appropriate for the diagnosis or management of a patient's medical condition, as determined by clinical guidelines and payer policies.

47. Medical Malpractice: Negligence or misconduct by healthcare professionals that results in injury, harm, or death to patients, leading to legal claims, settlements, and liability insurance coverage.

48. Meaningful Use: The utilization of certified electronic health record (EHR) technology to improve quality, safety, efficiency, and patient engagement in healthcare, as defined by the Centers for Medicare & Medicaid Services (CMS).

49. Mental Health Parity and Addiction Equity Act (MHPAEA): Legislation that requires health insurance plans to provide equal coverage for mental health and substance use disorder benefits compared to medical and surgical benefits, ensuring non-discrimination in insurance coverage.

N

50. National Practitioner Data Bank (NPDB): A confidential information clearinghouse that collects and discloses adverse actions taken against healthcare providers, including malpractice payments, licensure actions, and professional misconduct.

51. Nonprofit Organization: An entity that operates for charitable, educational, religious, scientific, or public service purposes without the primary goal of generating profits for owners or shareholders, often eligible for tax-exempt status.

O

52. Office for Civil Rights (OCR): A division of the U.S. Department of Health and Human Services (HHS) that

enforces federal laws protecting individuals' rights to access and control their health information, such as the Health Insurance Portability and Accountability Act (HIPAA).

53. Office of Inspector General (OIG): An independent agency within the U.S. Department of Health and Human Services (HHS) that investigates fraud, waste, and abuse in federal healthcare programs, issues guidance on compliance, and imposes penalties for violations.

54. Outpatient Prospective Payment System (OPPS): A reimbursement methodology used by Medicare to pay hospitals and ambulatory surgery centers for outpatient services based on a set payment rate per service or procedure.

P

55. Patient Protection and Affordable Care Act (PPACA): The formal name for the Affordable Care Act (ACA), signed into law in 2010 to expand access to healthcare insurance, regulate insurance practices, and improve healthcare quality and affordability.

56. Pharmacy Benefit Manager (PBM): An entity that administers prescription drug benefits on behalf of health plans, employers, and government programs, negotiating drug prices, dispensing medications, and overseeing formulary management.

57. Physician Self-Referral Law (Stark Law): Legislation that prohibits physicians from referring patients to entities for designated health services in which they have a financial interest, aiming to prevent conflicts of interest and ensure medical decision-making is based on patient needs.

58. Privacy Rule: The component of the Health Insurance Portability and Accountability Act (HIPAA) that sets national standards for the protection of individuals' health information, defining who can access, use, and disclose protected health information (PHI).

59. Provider-Based Entity: A healthcare facility or department that meets Medicare's criteria for being an integral part of a hospital, allowing it to bill for services at higher rates and receive enhanced reimbursement.

Q

60. Quality Improvement Organization (QIO): Organizations that work under contract with the Centers for Medicare & Medicaid Services (CMS) to improve the quality of care delivered to Medicare beneficiaries, conducting reviews, education, and interventions to enhance patient outcomes.

R

61. Reimbursement: The payment or compensation received by healthcare providers for services rendered to patients, typically from insurance companies, government payers, or patients themselves.

62. Retrospective Review: The assessment of healthcare services, claims, or utilization after they have been provided, focusing on appropriateness, medical necessity, quality of care, and compliance with regulations.

S

63. Stark Law: See Physician Self-Referral Law.

64. State Children's Health Insurance Program (CHIP): A joint federal-state program that provides health coverage to children in low-income families who do not qualify for Medicaid, offering a range of benefits and services based on eligibility criteria.

65. Substance Abuse and Mental Health Services Administration (SAMHSA): An agency of the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance behavioral health, prevent substance abuse, and promote recovery from mental illness and addiction.

T

66. Telemedicine: The use of telecommunications technology to provide remote clinical services, consultations, monitoring, and education, enabling healthcare professionals to deliver care to patients at a distance.

67. Third-Party Administrator (TPA): An entity that processes claims, manages benefits, and provides administrative services on behalf of self-insured employers, health plans, and other organizations, serving as an intermediary between payers and providers.

68. Truth in Negotiations Act (TINA): Legislation that requires contractors to submit cost or pricing data that are accurate, complete, and current when negotiating contracts with the federal government, promoting transparency and fairness in pricing.

U

69. Utilization Review: The evaluation of healthcare services, procedures, and resources used by patients to determine medical necessity, appropriateness, efficiency, quality of care, and compliance with regulations and guidelines.

V

70. Value-Based Care: A healthcare delivery model that emphasizes improving patient outcomes, reducing costs, and enhancing patient experience by rewarding providers for achieving quality, efficiency, and safety goals rather than volume of services.

71. Veterans Health Administration (VHA): The healthcare system of the U.S. Department of Veterans Affairs (VA) that provides medical services to eligible veterans, including hospitals, clinics, long-term care facilities, and mental health programs.

W

72. Whistleblower: An individual who reports fraud, waste, abuse, or unethical behavior within an organization to authorities, such as the government, regulatory agencies, or law enforcement, often

protected by anti-retaliation laws.

73. **Workers' Compensation:** A state-mandated insurance program that provides medical benefits and wage replacement to employees who suffer work-related injuries or illnesses, covering medical expenses and lost income during recovery.

X

74. **XML (eXtensible Markup Language):** A language used for encoding documents in a format that is both human-readable and machine-readable, facilitating the exchange of structured data between different systems and applications.

Y

75. **Young Adult Coverage:** The provision of health insurance coverage for individuals between the ages of 19 and 26 under their parents' health plans, as required by the Affordable Care Act (ACA) to expand access to healthcare for young adults.

Z

76. **Zero Tolerance Policy:** A strict approach to enforcing compliance with laws, regulations, policies, and ethical standards within a healthcare organization, emphasizing the consequences of violations, such as termination, fines, and legal action.