ED Operations Dictionary

Summary of the 2018
ED Benchmarking Definitions Summit

Emergency Department Operations Dictionary,

Summary of the 2018 ED Definitions Summit

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Introduction:

In order to update and expand its definitions, the ED Benchmarking Alliance (EDBA) held its 4th ED Definitions and Benchmarking Summit in 2018. Forty-six participants from key stakeholders in emergency care were invited to participate in the two-day conference that included reviewing prior definitions, framing areas of controversy, and developing consensus on definitions and concepts. The objective of this summit was to update definitions from 2014. This involved the addition of new terminology and metrics to reflect changes in emergency care. It also served to introduce financial definitions related to reimbursements for ED care. This comprehensive set of definitions could be the resource standard for industry-wide application.

Represented groups included community and academic emergency medicine physicians and nurse practice leaders, ED and hospital administrative leadership, professional societies, education and research leaders within the specialty, electronic health record (EHR) system vendors, and federal regulatory agencies. This is an unauthorized version of those proceedings.

The following individuals made significant contributions to the summit and its outputs:

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GENERAL DEFINITIONS	
People	
ED Personnel	
ED Call-Back Nurse or Provider	A health care staff member who conducts follow-up phone calls with patients. The call may involve the ED experience and/or the patient's condition, to communicate any results unavailable during the visit, or to coordinate subsequent care.
ED Case/Care Manager	A health care staff member with training in case management. Duties may include reviewing cases for inpatient admission, facilitating bed placement, ensuring appropriate ED use, and arranging home care, follow-up care, transport, and nursing home care.
ED Crisis Worker	A licensed social worker with psychiatric experience who provides assistance to the ED in evaluating and assisting in the disposition of patients presenting with behavioral health issues.
ED Critical Care Provider	A provider who often has critical care training or experience and cares exclusively for critical care patients in the ED.
ED Discharge Team	A team of health care providers, typically a nurse and a technician, dedicated to the discharge of the patient.
ED Data Analyst	A data specialist supporting ED staff with data analytics key to monitoring, measuring, and managing ED operations.
ED Greeter	A non-licensed individual, often stationed in the ED waiting area, who provides information, comfort, and escort service for patients and their families.
ED Greeter Nurse	An experienced nurse positioned at the entrance of the ED who quickly identifies patients that need immediate bedding and timely evaluation by a provider. Also called a Pivot Nurse or Segmentation Nurse (1,2).
ED Health Unit Clerk (HUC)	A non-licensed clerical person responsible for answering telephones, calling consulting physicians, maintaining charts, updating the patient log, and other clerical tasks to support work of the ED.
ED Information Technology (IT) Specialist	An information technology specialist dedicated to providing hardware support for computers in the ED.
ED Medical Assistant	A health care worker who performs clerical and clinical duties in support of an ED licensed health care provider, such as a physician, PA, nurse, or NP (3).
ED Medical Billing Specialist	A clerical worker who processes insurance claims for payment of services performed by a physician or other health care provider working in the ED (4).
EM Medical Coder	A clerical worker who analyzes patient charts and assigns the appropriate billing code. These codes are derived from International Classification of Disease (ICD 10) codes and corresponding CPT treatment codes with any related CPT modifiers (3).
ED Nurse Practitioner (NP)	A Nurse Practitioner is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. In some states, NPs have license to practice and prescribe independent of a physician (5).

ED Patient Flow Coordinator (PFC)/Patient Flow Facilitator (PFF)	A clinical health care staff member dedicated to improving ED patient flow by providing oversight and assistance with ED dispositions. The PFC monitors for and seeks to improve ED process deficiencies, bottlenecks, waits, and delays. The PFC monitors some or all subsets of processes: input, throughput, and outflow (6,7,8)
ED Pharmacist	An ED-based licensed professional responsible for providing comprehensive clinical pharmacy services including therapeutic consultation and formulation in the ED (9).
ED Physician Assistant (PA)	An ED based licensed health care provider trained in an accredited physician assistant training program to provide diagnostic, therapeutic, and preventive health care services as supervised by a physician. They are also authorized to prescribe medications.
ED Physician or Provider-in-Triage (PIT)	ED physician or advanced practice provider evaluating patients in the triage area, as part of patient intake, to initiate early testing and/or treat and release patients. (10,11,12)
ED Provider	A physician or advanced practice provider (Nurse Practitioner or Physician Assistant) staffing the ED and providing care to its patients.
ED Scribe	A HIPAA-trained, clerical worker tasked with documenting in the medical record on behalf of the ED provider (13,14)).
ED Transport Tech	A staff member based in the ED who is tasked with transporting patients within the ED, to other departments, and/or for testing and treatment.
ED Triage Nurse	A traditional nurse role tasked with the initial sorting of patients and the assignment of acuity (by ESI (emergency severity index), CTAS (Canadian triage system) etc.
Emergency Medicine Advanced Practice Provider (APP)	A licensed advanced practice professional, this may include NPs and PAs, who work in the ED.
Emergency Medicine Physician	A Physician who is board certified (or board eligible) by one of the following specialty boards: the American Board of Emergency Medicine (ABEM), the American Osteopathic Board of Emergency Medicine (AOBEM), or the equivalent international certifying body recognized by ABEM or AOBEM (15).
Emergency Physician	The physician of record for the ED patient encounter.
Emergency Nurse	A nurse professional, caring for patients in the ED.
Pivot Nurse/Patient Segmentation Nurse	An experienced nurse positioned at the entrance of the ED who quickly identify patients that need immediate bedding and urgent or emergent evaluation by a provider. Also called a Greeter Nurse (16).
Patient Populations	
Acute Care Patient Rate	The proportion of ED visits treated in traditional rooms in beds, with higher acuity (typically ESI 1 or 2) and a higher likelihood of admission. These patients are designated as not Fast Track or Mid Track eligible.
Behavioral Health Patient Rate	The proportion of patients who present and are dispositioned with a complaint primarily or secondarily consistent with a mental health illness and/or substance abuse disorder.
Critical Care Patient Rate	The proportion of patients requiring resuscitation and life saving measures, typically admitted to an ICU.

Fast Track Patient Rate	The proportion of ED visits treated in a designated low acuity area (often called a Fast Track) typically with ESI 4 and 5 designation and anticipated discharge to home.
Geriatric Patient Rate	The proportion of ED patients ages 65 years or older.
ICU Patient Rate (ICU Admission Rate)	The proportion of ED visits requiring an Intensive Care Unit bed upon admission.
Infant Patient Rate	The proportion of ED patients under the age of <2 years.
Mental Health Patient Rate	The proportion of patients who present and are dispositioned with a complaint primarily or secondarily consistent with a mental health illness (depression, suicidal ideation, psychosis, etc.)
Mid Track Patient Rate	The proportion of ED visits treated in a designated middle acuity area (often called a Mid Track or Vertical Model) typically with ESI 3 designation and anticipated discharge to home.
Neonatal Patient Rate	The proportion of ED patients under the age of 28 days.
Patients Admitted (ED Admission Rate)	The proportion of patients that do not go home or get transferred. This may involve both inpatient admissions and all categories of observation.
Patients Discharged (ED Discharge Rate)	The proportion of ED patients discharged at the completion of their ED encounter.
Patients Transferred-In (Transfer-In Rate)	The proportion of all ED patients who were transferred into an ED from an outside hospital from any origin to the ED.
Patients Transferred Out (Transfer-Out Rate)	The proportion of ED patients transferred to another facility to continue their medical care.
Pediatric Patient Rate	The proportion of ED patients under the age of 18 years.
Substance Abuse Patient Rate	The proportion of patients who present and are dispositioned with a complaint primarily or secondarily consistent with substance abuse disorder (i.e. substance abuse overdose, alcohol abuse or intoxication, requests for detoxication, etc.).
Trauma Patient Rate	The proportion of patients designated as needing trauma care, either by the ED or trauma providers.
Process	
Input	
ED Diversion	The process whereby an ED requests to be temporarily by-passed for emergency medical services (EMS) patient transports and referring facility patient transfers.
EMS Offloading	The process whereby the patient is transferred to an ED space and care is assumed by the ED; report is given and a hand-off occurs.
ED Intake	The process of receiving, identifying, sorting, and ensuring the security of persons seeking access to care in the ED.
Full Registration	The process of identifying and recording information to generate a patient-specific record. The collecting of information on financial responsibility for billing along with sociodemographic details is part of the full registration process. Full registration must follow the MSE according to EMTALA law.
Hospital Diversion	The process whereby a hospital requests temporary diversion of a patient to other institutions

Identification/ Quick Registration (Quick Reg)	The process of collecting information (with at least two unique patient identifiers) necessary to initiate and record a patient encounter. This is a step of the patient registration process.
Medical Screening Exam (MSE)	The process whereby a patient is evaluated for an emergency medical condition. The process must meet federal regulations (i.e.: EMTALA) and be performed by "qualified medical personnel". The process includes stabilization of the patient within the capability of the facility (17).
Patient Segmentation/Patient Streaming/Split Flow	The process by which ED patients are triaged to different care areas based upon triage acuity and expected resource utilization (18,19).
Triage	The process of clinically assessing the patient's acuity and identifying the appropriate area within the department and the resources needed for patient care.
Throughput	
Care Initiation	The process of beginning diagnostic or therapeutic interventions (generally including labs, imaging, and medications).
Consultation	The process of obtaining an evaluation and recommendations from specialty physicians or professionals for an ED patient from request to recommendations.
ED Imaging	The process of imaging diagnostics for an ED patient from order and transport to results.
ED Lab Testing	The process of lab testing for an ED patient from order and collection to results.
Nurse Assignment/Staffing Model	The process of assigning patients to nurses: 1) Primary Care Nursing- A nurse assignment model whereby a single nurse is responsible for all of the care of a patient 2) Zone Nursing- A nurse assignment model whereby nurses work as a team and care for patients together in a designated zone.
Provider-Patient Assignment Model	The process of assigning patients to providers: 1) Free Range Staffing- A provider assignment model whereby providers self-assign themselves to arriving patients. 2) Zone/Team Assignment- A provider assignment model whereby providers are assigned patients in a zone or as a team. 3) Rotational Assignment-A provider assignment model whereby providers are assigned patients in rotation.
Telemedicine	The use of interactive telecommunications equipment to provide patient care that includes, at a minimum, face-to-face interaction via real-time audio and/or video interface.
Vertical Model/Vertical Flow	The practice of streaming intermediate acuity patients to a designated area and treating them in lounge chairs instead of in ED stretcher or beds (20,21).
Output	
Boarding	The process of holding an admitted patient in the ED while waiting for an in-hospital bed. Can also be defined as a time interval (see later section).
ED Admission	The process where the patient transitions from ED to inpatient care. This may involve observation or inpatient status. Admission may involve acceptance, hand-off, bed assignment, team assignment, and transport.

ED Death	The occurrence of death in an ED patient.
ED Departure	The process whereby the patient physically leaves the ED after the encounter is completed.
ED Disposition	The process of determining the destination for a patient after the completion of the ED evaluation. Locations often includes discharge, hospital admission, observation or transfer. Can also be used as a term meaning destination or status.
ED Discharge	The process of completing a patient's ED care, releasing them from the ED and actual departure from the facility. This includes educating the patient regarding the treatment plan and the distribution of discharge documents.
ED-to-Hospital Handoff	The process through which pertinent information regarding an ED patient's current clinical status is communicated to the inpatient staff assuming care of the patient being admitted.
ED Transfer	The process of completing a patient's ED care and releasing the patient to another facility for continued care. This is often done when a higher level of care, or specialized care is unavailable at the source facility, or at the patient's request.
Team Assignment (Inpatient)	The process of determining the exact inpatient team designated for the patient. This may be a complicated and lengthy process.
Space	
Specialty Emergency Departments	
Emergency Department (ED)	A facility serving an unscheduled patient population with anticipated needs for emergency medical, surgical, or behavioral health care. Such locations receive emergency medical service (EMS) transports 24 hours a day and 7 days a week. (22).
Geriatric ED	An emergency department, or space within an ED, providing a multi-disciplinary team of care providers focused on the unscheduled urgent and emergent medical, surgical, or mental health care needs of the geriatric population (23).
Oncology ED	An ED dedicated to providing multi-disciplinary urgent or emergent care for oncology patients. An ED receives emergency medical service (EMS) transports 24 hours a day and 7 days a week.
Pediatric ED	A facility, or space within a larger ED, serving an unscheduled patient population younger than 18 years of age with anticipated needs for urgent or emergent medical, surgical, or behavioral health care. Such locations receive EMS transports 24 hours a day and 7 days a week. (24).
Psychiatric ED	A hospital location serving an unscheduled emergency behavioral health patient population that receives EMS transports 24 hours a day and 7 days a week (25).
Women's ED	An ED dedicated to providing multi-disciplinary urgent or emergent care for women that receives emergency medical service (EMS) transports 24 hours a day and 7 days a week.
ED Geographic Zones	
Admission Holding Unit	A designated unit, often within or adjacent to the ED, for patients awaiting admission processing and inpatient bed placement. The diagnostic and

	therapeutic needs of the patients at this stage no longer require an ED treatment room (26).
Behavioral Health Suite	An area dedicated to the needs of Behavioral Health patients, with safety modifications, and space for mental health workers.
Care Initiation Area (CIA)	An area near intake, where the assessment of the patient is expedited (lab and imaging), as the patient waits for a treatment space. This may also be called a Rapid Assessment Zone (RAZ).
Discharge Check-Out Zone	A space, usually adjacent to the ED, where patients go through the discharge process, including receiving instructions and prescriptions. Copayments may be made here.
Discharge Waiting Area	An area allocated for ED patients who no longer need diagnostic or therapeutic interventions and are awaiting discharge (process and/or paperwork).
ED Observation Unit/Clinical Decision Unit (CDU)	A specialized unit for the continued management of ED patients following their initial ED care, classified as in-hospital yet outpatient care that is managed by the ED.
ED Fast Track/Low Acuity Treatment Area	An area within the ED that is dedicated to the treatment of patients with minor illnesses, wounds, and injuries (27,28,29).
ED Treatment Room	A room within the ED in which complete evaluation and treatment can be delivered to the patient.
ED Treatment Space	A space in the ED to which a patient can be assigned for care that is not enclosed with walls. It may or may not be suitable for complete evaluation and treatment. It may include hallway spaces or group treatment areas.
Intake Area	An area where ED arrival activities - including entry security checks, identification, registration and triage - occur prior to placement into a treatment space, treatment room, or waiting area.
Internal Waiting Room	A room within the ED, contiguous with a geographic zone where patients may wait for test results and disposition.
Mid Track	An area (may also refer to the service line) dedicated to the care of intermediate acuity patients, with care often rendered in chairs following a vertical model (30,31,32).
Procedure Room	A room dedicated to patients needing procedures, particularly mid track vertical patients that need a stretcher.
Rapid Treatment Unit (RTU)/Rapid Evaluation Unit (REU)	A zone or area near the patient arrival area, where intake and management of lower and middle acuity patients occurs, without placement in the main ED. The majority of RTU patients are discharged (33, 34).
Rapid Assessment Zone (RAZ)	An area near intake, where the assessment of the patient is expedited (lab and imaging), as the patient waits for a treatment space (35). This may also be called a Care Initiation Area (CIA).
Results Waiting Area	An area where patients await diagnostic or consultative results after the initial assessment is completed and the care plan is initiated. It may be within the department or outside of it.
Sedation Room/Suite	A room dedicated to the delivery of conscious sedation in the ED and favored by pediatric ED's.

Triage Area	An area where the traditional triage assessment component of the intake process (e.g., history, focused physical exam, vital signs, illness acuity assessment) takes place.
Other Terminology	
ED Flow Terminology	
Advanced Nursing Protocols/Advanced Triage Order Sets	Standardized chief complaint driven order sets implemented by nursing staff after triage but before their first provider evaluation (36).
Bed Ahead Processes	The practice of regularly running the board to identify patients likely to be discharged, and indicating the next bed that could be opened for an incoming more acute patient.
Contested Admission	An admission for which there is disagreement about the disposition, the appropriate service for the patient and/or the scope of the workup required before the admission is accepted (37,38).
ED Crowding	The condition of having more ED patients than designated treatment spaces available in the ED (39,40). Crowding typically follows boarding.
ED Callback Program	A structured program to call patients after ED discharge related to the following: Clinical status follow up, delayed laboratory or imaging results reporting, or follow up care.
ED Disposition	The destination and or/status for a patient after completion of the ED evaluation. ED dispositions include admission, discharge, transfer and observation. ED disposition is also a process.
ED Telemedicine (Physician-to-Physician)	Telemedicine technology applied to provider-to-provider communication program through which a local provider can remotely receive a real-time (video- and audio-enabled) medical or surgical specialist consultation.
Immediate Bedding	The process of rapidly placing sicker patients into ED beds.
"Pull to Full"	The process of placing patients into beds and commencing bedside triage, while the ED has capacity (41).
Rapid Response Team	An Interdisciplinary specialist team available on demand to facilitate the rapid treatment of time-sensitive emergency conditions (i.e. ST elevation myocardial infarction, stroke, sepsis, trauma).
Telemedicine at ED Triage	Telemedicine technology that provides physician-to-patient telemedicine services at triage.
"The Swarm"	The process of ED intake whereby the entire team begins the patient encounter together with parallel processing (42).Sometimes called Team Intake model.
Transition Orders/Holding Orders	Admission orders signed by ED providers which allow ED patients to be transferred to inpatient beds before the admitting provider sees them (43).
Hospital Flow Terminology	
Discharge by Noon (DBN)/ Early Discharge Initiatives	A hospital process wherein capacity is created by coordinating hospital discharges earlier in the day, to help alleviate ED boarding (44).
Discharge Lounge	A place to hold discharged patients awaiting transportation from the hospital, thereby creating inpatient capacity (45).

Elective Surgical Procedure Smoothing	A hospital process whereby the hospital load-levels elective surgical procedure schedules to minimize episodes of peak demand (i.e. moving procedures to late week or weekend) (46).
"Flash Rounds" Discharge Rounds	An innovation whereby the inpatient team conducts rapid discharge planning rounds, focused only on patients leaving the hospital, to facilitate early in the day discharges.
Full Capacity Protocol	This protocol involves a hospital initiating specific actions, particularly moving admitted ED patients to inpatient hallways, when the ED is crowded (47).
Hospital Diversion	The process whereby a hospital requests temporary diversion of a patient to other institutions for specific services that are temporarily unavailable.
Inpatient Admission Status (Inpatient)	A hospital status that designates the patient as no longer in outpatient status, For Medicare beneficiaries, care is now covered under Medicare Part A.
Transition of Care	The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another (48).
Observation Terminology	
ED Observation	An admission status in which the patient's hospital stay is billed as an outpatient service but is cared for by ED personnel. This involves a transition of care, often to an ED observation unit, but can occur despite the patient staying within the ED or being placed in a unit outside of the ED. This is differentiated from Hospital Observation which is completed by a non-ED service (49).
ED Observation Unit	A specialized unit, often adjacent to the ED, for the continued management of ED patients following their initial ED care. The patient is managed by ED personnel and in the hospital, but the encounter is designated as outpatient care.
Hospital Observation	A subset of in-hospital visits for which a patient has an in-hospital stay billed as an outpatient service. This does not include patients who have their observation care in the ED or in an ED observation unit (50,51).
Hospital/In-Hospital Observation Unit	A specialized unit for continued management following initial ED care, typically managed by Hospitalists with anticipated LOS under 24 hours.
OPERATING CHARACTERISTICS	
Emergency Department	
Behavioral Health Rate	The proportion of ED visits with a complaint consistent with a mental health illness (depression, anxiety, suicidal ideation or psychosis) and/or substance abuse disorder.
ED Acuity	The general level of expected patient illness, urgency for clinical intervention, or intensity of resource use in an ED environment (52). 1) By ESI-Patient breakdown according to the Emergency Severity Index (or the Canadian Triage Assessment Scale) designate the acuity of patients upon arrival (53). 2) By E&M Codes-Patient breakdown according to E&M codes. High Acuity is defined as proportion of patients with E&M coding 99284, 99285 and 99291 (critical care) (54).

ED Age Mix	Proportion of ED visits for each of the following age categories: <1-month, 1 month - 2 years, 2-12 years, 13-17 years, 18-25 years, 26-35 years, 36-44 years, 45-54 years, 55-64 years, 64-75 years, 74-84 years, 85+ years.
ED Admission Rate	The proportion of all ED patients admitted for in-hospital care. In other words, any patient who has not been discharged, transferred or died.
ED Daily Census	The number of ED encounters per 24-hour period (Patients Per Day or PPD)
ED Payor Mix	The proportion of ED visits across insurance categories. These can include Medicare, Medicaid, private, self-pay, workman's comp, auto/accident or other insurance.
ED Physician Board Eligibility/ Board Certification Rate	The proportion of ED physicians with American Board of Emergency Medicine Certification or Eligibility that are credentialed to work in an ED or practice group.
ED Physician Contract Model	The model under which physician services are provided to a hospital. Examples include hospital employee; democratic group; contract management group; locum tenens; academic faculty.
ED Provider Staffing Model	The model of ED coverage/ provider mix of Physicians, NPs, and PAs.
ED Staffing Model	The model of clinical and clerical workers staffing the ED contributing to the direct care delivery of ED patients. Staffing can include physicians (attending and residents), PAs, NPs, nurses, technicians, paramedics, pharmacists, social workers, case managers, and others.
ED Transfer Rate	The proportion of patients transferred to another facility for continued medical care.
ED Treatment Spaces	The count of designated spaces utilized for the treatment of patients. These can include beds in hallways and recliners (53).
ED Type	The ED type involves stratifying EDs by structural, funding, health care mission, specialty care, or hospital affiliation characteristics (53). These can include: 1. hospital-based vs. free-standing EDs 2. academic vs. academic affiliated vs. community practice 3. critical access vs. non-critical access 4. referral centers vs. tertiary care 5. private vs. public vs. federally funded and 6. specialty care designations such as trauma center, burn center, percutaneous coronary intervention center, transplant services, or nursing magnet status.
ED Volume (Annual)	The annual number of ED visit encounters over 12-month period.
EMS Arrival Rate	The proportion of ED patients arriving by EMS.
ICU Admission Rate	The proportion of all ED patients admitted for ICU care. This includes all subsets of Observation patients.
Geriatric Rate	The proportion of ED patients over the age of 65 years.
Pediatric Rate	The proportion of ED patients under the age of 18 years.
Telemedicine	The use of interactive telecommunications equipment to direct patient care that includes, at a minimum interaction via real-time audio and video interface.
Top Chief Complaint Mix	The proportion of ED visits falling within the top 10 chief complaints for ED patients versus all "other" chief complaints. There is no standardized chief complaint system in use.

Top Diagnoses Mix	The proportion of ED visits falling within the top ten ICD-10 codes for ED patients versus all "other" diagnoses.
Hospital	
Boarding	The process of holding an admitted patient in the ED while waiting for an in-hospital bed. Can also be measured as a time interval (see later section). It is a process, an operating characteristic and a time interval.
Consultation Services Available	All medical and surgical specialties (and sub-specialties) available to the ED for emergency consultation (53).
Hospital-Based Facilities for Acute Unscheduled Care	All facilities that provide acute or unscheduled medical care. These may include local / affiliated urgent care centers, hospital outpatient department for urgent care, hospital-based air transport, and hospital-based ambulance service.
Hospital Fiscal Designation	The ownership and funding status category for the hospital. This may include private non-profit, private for-profit, primarily federally funded, or primarily state or county funded.
Hospital Information Technology	Typically, this refers to the electronic health record and patient tracking system, but may include clinical decision support tools.
Hospital Licensed Beds	The maximum number of beds for which a hospital holds a license to operate. Licensed beds may exceed staffed beds or those in active use for patient care (55).
Occupied Beds	The number of in-hospital patient beds that are licensed, physically available, staffed by nursing, and occupied by a patient.
Physically Available Hospital Beds	The in-hospital patient beds that are licensed, physically set up, and available for use. These are beds regularly maintained for use by patients in the hospital, which furnishes accommodations with supporting services (such as food, laundry, and housekeeping). These beds may or may not be staffed but are physically available.(55)
Staffed Hospital Beds	The in-hospital patient beds that are licensed and physically available and for which nursing staff is on hand to attend to a patient who may occupy the bed. Staffed beds include those that are occupied and those that are vacant.
OPERATIONAL PERFORMANCE	
Time Stamps	
Admission Accepted Time	The time a patient is accepted for admission for bed assignment and care by an admitting in-hospital service. This may precede the actual care handoff to the admitting service.
Admission Ready Time	The time the ED provider caring for an ED patient determines that emergency care is complete such that a transition to in-hospital care is appropriate.
Bed Request Time	The time a request is made for a patient to receive in-hospital care (inpatient or observation status).
Care-Nurse Contact Time	The time of first contact with a non-triage nurse in the ED who initiates the care of the patient.
Consult Call Response Time	The time a consultant responds to a call for consultation.
Consult Call Time	The time of the interpersonal communication between the emergency care provider the consultant, when a request for a patient consultation occurs.

Consult Order Time	The time of the placement of an order for a consultation by the emergency care provider.
Consultant Arrival or Evaluation Time	The time a medical or surgical consultant is physically present in the ED to provide a consultation.
Consult Recommendations Time	The time the recommendations for care are provided by a medical or surgical specialist consultant associated with the requested consultation are received.
Decision to Admit Time/Admit Decision Time	The time a clinician determines a patient is ready for admission to the hospital.
Decision to Transfer Time	The time the provider makes the decision to transfer the patient to another facility (time of transfer request may be used as a proxy).
Disposition Decision Time	The time a disposition decision (discharge, admit, transfer) is documented.
ED Arrival Time	The time associated with the first evidence of a patient's presence in the ED
ED Departure Time	The time a patient physically leaves the ED after the emergency encounter, regardless of whether care has been completed.
EMS Arrival Time	The time EMS arrives in the ED with a patient as documented in the EMS record. As a result, it may or may not be the same as the "ED arrival time."
EMS Off-Loading/Patient Arrival Time	The time the EMS transported patient is transferred from the EMS stretcher to a treatment space or triage. The ED staff assumes the care of the patient at this time.
Final Radiology Read Time	The time of the final documented interpretation report for a radiologic image by a radiologist.
First Provider Contact Time	The time of the patient's first assessment by a provider qualified to complete an EMTALA compliant medical screening exam.
Hospital Discharge Time	The time the patients' in-hospital encounter is completed and the patient physically leaves the inpatient unit.
Imaging Available to Ordering Provider Time	The time a radiographic image is available for review by the ordering provider.
Imaging Start (or Initiation) Time	The time radiographic image acquisition begins.
Imaging Order Entry Time	The time an emergency care provider places an order for radiographic imaging.
Imaging Report Time	The time the radiology report associated with a radiographic imaging test is available to the ordering provider.
Imaging Scheduled Time	The time a radiographic image is scheduled for imaging technologists to complete.
Imaging Transport Time	The time a patient is moved from their ED room/space assignment for a radiographic imaging destination.
Provider Contact Time	The time a patient's encounter with a medical provider begins and the patient condition is assessed. The initiation of triage protocols does *not* equate with provider contact time.
Patient Roomed Time	The time the patient is assigned and placed into a (non-triage) ED care space.
Preliminary Radiology Read Time	The time the summarized, original radiographic report/reading is communicated to the ordering provider and/or documented by the interpreting radiologist.
Testing Completion Time	The time associated with the last diagnostic test ordered for a patient (generally including labs and imaging) after the start of their ED encounter.

Triage Time/Triage Start Time	The time the process of clinically assessing patient's acuity and identifying the provider type, space, and resources needed for anticipated care begins.
Time Intervals	
Standard Time Intervals	
Admit Decision to Departure (Boarding)	The interval from admit decision (admit order or bed request) to the time when a patient departs the ED. This is a time interval, but also a process and an operating characteristic.
ED Arrival to Provider Evaluation	The interval from ED arrival to their first contact with a provider who can initiate their ED care plan. This is often referred to as "door-to-doctor" or "door-to-provider" time.
ED Length of Stay (LOS)	The interval from ED arrival to ED departure.
ED Length of Stay Admitted patients	The interval from ED arrival to ED departure for admitted patients.
ED Length of Stay Discharged Patients	The interval from ED arrival to ED departure for discharged patients.
ED Length of Stay Transferred Patients	The interval from ED arrival to ED departure for transferred patients.
Non-Standard Time Intervals	
Admit Decision to Admission Accepted	The interval from the decision to admit and the admission being accepted for in-hospital care.
Admission Accepted to ED Departure	The time interval from acceptance of a patient for admission and the patient's physical departure from the ED.
Decision to Admit to ED Observation Order (for In-ED Observation)	The interval from the decision to admit a patient from the ED for in-hospital observation to the time the observation order being placed.
Decision to Discharge to ED Departure	The interval from the decision to discharge to the patient physically departs the ED.
ED Arrival to Triage	The interval from ED arrival to the initiation of ED triage.
ED Arrival to Treatment Space	The interval from ED arrival to the patient being assigned and placed in a patient care space.
Hospital Length of Stay	The interval from admit decision (may be admission order or bed request), to hospital discharge (patient out of the bed). Inpatient LOS begins when the patient is admitted (admission is a status not a place) and boarding time counts as inpatient LOS.
Disposition Decision to Departure	The interval from disposition decision to physical departure from the ED.
Provider Contact to Disposition Decision	The interval from provider contact to the disposition decision.
Provider Contact to Testing Initiation	The interval from provider contact to initiation of testing.
Testing Initiation to Testing Completion	The interval from the initiation of ED testing to the completion of all tests.
Testing Completion to Disposition Decision ("Data to Decision")	The interval from the completion of all tests to the disposition decision time.

Triage to Treatment Space (roomed)	The interval from the initiation of triage (triage start) to the patient is placed into a (non-triage) patient care space.
Triage to Provider	The interval from triage completion to provider contact.
Treatment Space to Provider	The interval from patient being assigned and placed in a (non-triage) patient care space to their contact with the provider.
Ancillary Time Intervals	
ED Bed Cleaning Turn-Around-Time	The interval when a bed is vacated to when it is cleaned and ready for the next patient.
ED Bed Cleaning Request to Initiation	The interval from the ED bed, room, or care space cleaning request placement to cleaning begins.
ED Transport Time	The time transport is called to patient is transported out of the department.
Imaging Turn-Around-Time	The interval from the placement of an order for an imaging test to when the results are available to the ordering provider. Results may be "preliminary" or "final," depending on the ED's policy of decision-making with for a given imaging modality.
Imaging Ordered to Initiated	The interval from when an imaging test is ordered to when the test is initiated.
Imaging Start to Preliminary Report	The interval from imaging test initiation to the preliminary report available to the ordering provider.
Imaging Start to Final Report	The interval when an imaging test is initiated to the final report being available to the ordering provider.
Laboratory Test Turn-Around-Time	The interval from placement of an order for laboratory testing until results are available to the ordering provider
Lab Order to Collected	The interval from when a lab is ordered to when the lab sample is collected from the patient.
Lab Collected to Received	The interval from when a lab sample is collected from the patient to when it is received by the lab.
Lab Received to Results	The interval from when the lab receives a lab specimen to when results are provided.
Transport Request to Arrival	The time transport is called to transport personnel arrive.
Behavioral Health Time Intervals	
Bed Search Time to Mental Health Disposition	The interval from when bed search begins to the time when patient disposition decision is documented (for mental health patients referred for inpatient psychiatric care).
Medical Stability/Cleared to Initial Behavioral Health Assessment	The interval from when the patient is considered medically stable or cleared for mental health services to the time when the first behavioral assessment begins.
Mental Health Assessment to Bed Search Time Start	The interval from when mental health assessment initiation begins to the time when the bed search begins (For mental health patients referred for inpatient psychiatric care).
Mental Health Assessment to ED Discharge	The interval from initiation of the mental health assessment to the time of ED discharge (for mental health patients referred for outpatient psychiatric care).
Mental Health Assessment to Mental Health Disposition	The interval from initiation of the mental health assessment to time the patient disposition decision documentation.

Consult Time Intervals	
Consult Initiation to Consult Completion	The interval from evaluation initiation to consult completion.
Consult Completion to Recommendations	The interval from consult completion to recommendations provided.
Consult Request-to-Consultant Response	The interval from consult request to the consultant response to the consult request.
Consultant Response to Evaluation Initiated	The interval from a consultant response to the evaluation initiation.
Consult Turn-Around-Time	The interval from consult request placed to consult recommendations.

Incomplete Encounters	
Against Medical Advice (AMA)	A legal definition, the proportion of patients in this category who leave before treatment is complete and against the advice of the provider (and after the risks and benefits of further care have been explained and documented). It is expressed as a rate or percentage of ED visits.
Eloped	The proportion of all patients who leave the ED before treatment is complete, without a discussion of their refusal of care, and before the disposition decision is made by the care provider. Patients are placed in this category when there is not enough information to assign a more specific incomplete encounter category. It is expressed as a rate or percentage of ED visits.
Left Before Treatment Complete (LBTC)	The proportion of all patients who leave the ED before a licensed medical provider (An MD or APP) determines care is complete. Completion of care is indicated by a disposition decision (i.e., home, admit, transfer, etc.) LBTC = LWBS + AMA + Eloped. It is expressed as a rate or percentage of ED visits Elopements and AMA are subsets of left subsequent to being seen LSBS. (35)
Left Without Being Seen (LWBS)	The proportion of patients who leave the ED before initiation of the MSE (expressed as a rate or percentage of ED visits).
Categories of LWBS	
Left Before Being Seen (LBBS)	The proportion of patients who leave the ED before evaluation by a licensed (LBBS) care provider qualified to complete a medical screening exam and initiate treatment. It is expressed as a rate or percentage of ED visits (33)
Left Without Being Seen-No Intervention (LBBS-NI)	The proportion of patients who leave the ED before evaluation by a licensed care provider qualified to complete a medical screening exam and initiate treatment, without any interventions. It is expressed as a rate or percentage of ED visits.
Left Without Being Seen-With Intervention (LBBS-WI)	The proportion of patients who leave the ED before evaluation by a licensed care provider qualitied to complete a medical screening exam and initiate treatment after interventions have been initiated (often per triage nursing protocol orders).
Left Subsequent to Being Seen (LSBS)	The proportion of patients who leave the ED after evaluation by licensed care provider qualified to complete a medical screening exam and initiate treatment (typically a physician, PA or NP) but before the disposition decision by the care provider. Elopements and AMA are a subset of LSBS. It is expressed as a rate or percentage of ED visits.
Patient Experience	

Complaint Ratio	All patient-initiated expressions of concern regarding ED-related care that are 1) written 2) called in, or 3) brought to the attention of the ED management or hospital administration. Complaint ratios are expressed as complaints per 1,000 ED visits by convention.
Patient Satisfaction	The proportion of patients reporting satisfaction, often along a 5-point Likert Scale, by survey or solicitation (56).
STAFFING DEFINITIONS	
Advanced Practice Provider Hours Total	The total number of APP hours per day, week, month, year.
Advanced Practice Provider Hours per ED Visit	The total number of APP hours per ED visit.
ED Physician Scheduling Model	The plan which articulates the staff start and stop times for provider shifts.
ED Board-Eligibility/ Board-Certification Rate	The proportion of ED physicians with American Board of Emergency Medicine Certification or Eligibility that are credentialed to work in an ED or practice group.
Non-Nursing Caregiver Hours	The number of scheduled non-nursing caregiver hours by day, week, month, year.
Number of Case/Care Management hours	The total number of non-utilization case management hours per day, week, month year.
Number of Nursing Hours	The total number of direct care clinical nursing hours per day, week, month, year.
Physician Hours Total	The total MD staffing hours per day, week, month, year.
Physician Hours per ED Visit	The total number of physician hours per ED visit.
Provider Hours per ED Visit	The total number of provider hours per ED visit.
Ratio of Worked Provider Hours to Patient Visits	The total number of direct worked provider hours divided by the total number of patient visits.
Staff hours per ED visit	The total number of staff hours, as defined as nurses and non-nursing caregivers doing clinical work, per ED visit.
Total Provider Hours	The total number of provider hours per day, week, month, year.
Work Hours per Unit of Service (WHPUOS)	The total number of staff worked hours (nurses, techs, unit clerks etc.) providing care on the ED floor, divided by the total number of patient visits.
UTILIZATION	
Behavioral Health Consultations Rate	The number of behavioral health consultations per 100 ED visits. This is a marker of the mental health burden on the ED.
Case/Care Management consultations Rate	The number of case management consultations per 100 ED visits, as a marker for discharge and admission decision burden on the ED.
CT Studies Rate	The number of contrasted and non-contrasted CT studies (not images) per 100 ED visits.
Electrocardiograms (ECGs) Rate	The number of ECGs performed per 100 ED visits.
Laboratory Studies Rate	The number of patients per 100 ED visits who have any lab specimen ordered and sent to the laboratory for processing and recording as a billable laboratory

	test. (This would include point of care testing where docking captured the order).
Medication Dosages Rate	The number of medication doses administered by any route (intravenous, oral, intranasal, or intramuscular) per 100 ED visits. (Total doses may be captured from an electronic dispensing system or from charges recorded by the pharmacy department).
MRI Studies Rate	The number of MRI studies (not images) per 100 ED visits.
Palliative Care Consultations Rate	The number of palliative care consultations arranged through the ED per 100 ED visits.
Plain Radiography Studies Rate	The number of plain film studies (not images) per 100 ED visits.
Point of Care Ultrasound Studies Rate	The number of ultrasound studies (not images) performed at the bedside by the emergency care provider per 100 ED visits. These studies are defined as having a billable limited study code and retained image(s) in the medical record.
Social Service Consultations Rate	The number of social worker consultations arranged through the ED per 100 ED visits.
Specialty Services Consultations Rate	The number of medical/surgical/specialist consultations per 100 ED visits.
Telemedicine Behavioral Consultations Rate	The number of behavioral health consultations performed via telemedicine route per 100 ED visits. This is a subset of the total behavioral health consultations listed above.
Ultrasound studies Rate	The number of formal ultrasound studies (not images) performed by the radiology department and reported to the ED per 100 ED patients.
BOARDING MEASURES	
Boarding Burden	The total hours of boarding, typically recorded by month.
Boarding Percentage	The proportion of total ED time in which patients are boarding in the ED by the total time of all patient care occurring in the ED (including boarding time).
Boarding Time (Admit Decision to Departure Time	The interval from admit decision (admit order or bed request) to the time when a patient departs the ED. This is a time interval but also an operating characteristic.
FINANCIAL GLOSSARY	
5010	A Revision (version 5010) and active version of the Health Insurance Portability and Accountability Act's standards for transaction and code-sets for electronic healthcare transactions. This standard applies to billing claims, referrals, claim status, eligibility, and remittances. Mandatory compliance date was January 1, 2012 (57).
(ACA)Affordable Care Act	The Patient Protection and Affordable Care Act of 2009 is a Federal law enacted in March 2010 often referred to as the ACA, PPACA, Health Care Reform Act, or Obamacare. The law has three main objectives: 1) to make affordable health insurance options more available to more people. This included subsidies that lowered the costs for individuals whose income was at or below 400% the federal poverty level; 2) it encouraged states to expand their Medicaid programs to cover all adults with income below 138% of the federal poverty level; and 3) It supports innovative medical care delivery

	methods designed to lower the costs of health care generally, including accountable care organization payments (58).
Accept Assignment	When a healthcare provider accepts as full payment the amount paid on a claim by the insurance company. This excludes patient responsible amounts, such as co-insurance or co-pay (59).
Accounts Receivable	The balance of money due to a health care (or other) organization for goods or services rendered but not yet paid. As a result, it represents money owed to the organization for services already provided whose expenses were covered by the organization's credit. This is represented on the balance sheet as an account asset (59).
Accounts Receivable Days	The number of days it takes an organization to be paid for services rendered using its credit to cover the cost of the services. This is often used as a measure for the efficiency of payment collections (59).
Adjusted Claim	Payment or credit to a healthcare provider made after modification or adjustment of a claim filed with a health care payor (often an insurer) for the payment for a patient's medical services (59).
Age Trial Balance (ATB) Reports	Financial reports that alphabetically list accounts receivable with outstanding balances. It reports one balance for each account by age (accounts receivable days) (60).
Aging	Unpaid insurance claims to a health care organization or patient billing balances for delivered patient services that are past due. Most medical billing software can generate a separate report for insurance claim aging and patient balance payment aging. These reports typically list balances grouped by 30, 60, 90, and 120 days (59).
Allowed Amount	Maximum payment the plan will pay for a covered health care service, inclusive of patient cost-sharing (deductible and co-pay) and insurer payment. May also be called "eligible expense," "payment allowance," or the "negotiated rate" (59).
Appeal	Request (often from a patient or provider) that a health insurer or plan review a decision that denied a patient eligibility for a benefit or denied payment (either in whole or in part) of a health insurance claim (59).
Applied to Deductible (ATD)	Amount of the charges for medical care or services that a patient's insurance plan determines the patient owes the organization that provided care. Many plans have a maximum annual deductible such that, once the deductible is met, remaining charges are then covered by the insurance provider (59).
Assignment of Benefits (AOB)	Agreement between an insurance company (or other payor) and a patient that permits the payor to make payments directly to the doctor or organization that provided medical services to the patient. This is designated in Box 27 of the CMS-1500 claim form (59).
Authorization	When a patient requires permission from the insurance company before receiving certain treatments or services (59).
Average Age of Plant Ratio (years)	Measure of the financial age of a hospital's fixed assets in years. Fixed assets are tangible pieces of property or equipment intended for long-term use that a hospital owns and uses in its operations to provide services and generate income. The calculation uses straight line-depreciation. The older the average age, the greater the short-term need for capital resources to replace/repair

	fixed assets. Lower values indicate a new fixed asset base and a lesser need for near-term replacement (59).
Average Hospital Length of Stay (LOS; days)	Calculated as the total number of days for all or a class (i.e., observation or admission) of in-hospital patients discharged over a given period (patient days). This measure is used as an indicator of efficiency in containing inpatient service costs. Formula: Average Hospital LOS = patient days ÷ total discharges (59).
Average Payment Period (APP; days)	A key metric (or solvency ratio) used by potential lenders to measure an organization's ability to meet its debt obligations. Specifically, it measures the average number of days it takes an organization to pay its vendors and providers for health care services delivered, understanding that this is done on credit until payments are received from health care payors (typically insurance companies). As a result, it is a measure of how efficiently an organization pays its bills (61).
Balance Bill	Amount of money to be paid to a healthcare provider or organization that remains on the bill for health care services that a patient's insurance plan does not cover. This amount is the difference between the actual billed amount and the maximum amount an insurer will pay for a covered health care service (the allowed amount), excluding the patient's deductible and co-insurance. The formula is: Charge - (deductible + co-pay + insurer payment) = balance bill. (62)
Beneficiary	Person or persons covered by the health insurance plan and eligible to receive benefits (61).
Blue Cross Blue Shield (BCBS)	An organization of affiliated insurance companies (approximately 450), independent of the association (and each other), that offer insurance plans within local regions under one or both association's brands (Blue Cross or Blue Shield). Many local BCBS associations are non-profit. BCBS sometimes acts as an administrator of Medicare in many states or regions (61).
Capital Expense (%)	Measure of the capital structure and degree of flexibility an organization might have in raising capital (59).
Capitation	Fixed payment to a health care provider or organization on a per-patient-enrolled basis to cover the costs associated with the patient's health care services over a defined period. This payment is not affected by the type or number of services provided (59).
Carrier	The insurance company or other payor with whom the patient has a contract to provide health insurance to cover the cost of incurred health care delivery expenses (61).
Current Procedural Terminology (CPT) Code	A set of billing codes developed by the American Medical Association and designated by the US Department of Health and Human Services as a national coding set for classifying medical, surgical and diagnostic procedures, diagnoses, and services provided to a patient in the delivery of health care. It serves as a common language to code medical services and procedures for reporting, billing, and research (63).
Category I Codes	CPT codes for medical procedures or services identified by five digits. They are organized in a sequence of sub-categories based on procedure or service type and patient anatomy (63).

Category II Codes	Optional “performance measurement” tracking CPT codes that are numeric with a letter as the last digit (example: 9763B). They were developed to better capture the clinical components of care provided to patients as is often described (but not limited to) in the “evaluation and management (E/M) services” assessment used for billing, so they have no independent billing value ($0). These codes are designed to improve the efficiency of data collection on the quality of care, provided in a way that reduces the need for individual chart review for standardized quality metrics (63).
Category III Codes	CPT codes that are assigned to track the utilization of emerging technologies, services, and procedures. These codes are for services that have not yet become Category I Codes, as many of the items have yet to be identified as safe or effective. Because of this, insurance claims for the care associated with these codes are often denied (64).
Charity Care	When medical care is provided at no charge or a reduced charge to a patient that cannot afford to pay. The definition of charity care is based on local formulas that the hospital must follow and is the difference between the calculated cost of care and the amount the patient can pay (59,65).
Chart Reconciliation	Chart reconciliation is the act of ensuring that a bill has been entered into the billing system for all billable patient visits. The reconciliation process generally involves both a check and recheck to ensure any missing charts requested for completion have been received and entered into the billing system (59).
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)	Federal health insurance program from the United States Department of Defense Military Health System. It provides civilian health benefits for military members who may be active duty, National Guard, Reserve Component members (limited eligibility), retirees, and/or their families and survivors. This has been renamed TRICARE and is managed by the Defense Health Agency (DHA) (59).
Claim (Insurance Claim)	Request for a benefit from an insurance company made by a beneficiary (patient) or their healthcare provider for items or services to be paid by the insurer. This can include payments on patient’s behalf for services received from a health care provider or organization or reimbursement for health care expense (59).
Clean Claim	A complete submitted insurance claim that has all the necessary correct information without any omissions or mistakes that allows it to be processed and paid promptly (59).
Clearinghouse	This is a service that transmits claims to insurance carriers. Prior to submitting claims, the clearinghouse scrubs claim and checks for errors. This minimizes the amount of rejected claims, as most errors can be easily corrected (62).
Centers for Medicaid and Medicare Services (CMS)	Federal agency which administers Medicare, Medicaid, HIPAA, and other health programs. Formerly known as the HCFA (Health Care Financing Administration) (59).
CMS 1500	Medical claim form established by CMS to submit paper claims to Medicare and Medicaid. Most commercial insurance carriers also require paper claims be submitted on CMS-1500's. The form is distinguished by its red ink (59).

Consolidated Omnibus Budget Reconciliation Act (COBRA) Insurance	Health insurance coverage available to an individual and their dependents after previous employment with a business having more than 20 full-time employees, with either voluntary or involuntary termination of employment for reasons other than gross misconduct. Because it does not typically receive company matching, it is typically more expensive than insurance when employed but does benefit from the savings of being part of a group plan. Employers must extend COBRA coverage to employees who are dismissed. COBRA was passed by Congress in 1986. COBRA coverage typically lasts up to 18 months after becoming unemployed and, under certain conditions, extends up to 36 months (59).
Coding	Process in which the patient's medical record is translated into the proper evaluation, diagnosis (ICD codes), and treatment codes (such as CPT and quality codes). This is for purposes including reimbursement, disease classification, and treatment (59).
Co-insurance	The percentage of costs of a covered health insurance you pay (20%, for example) after you have paid your deductible (62).
Collection Per Visit	The average dollar amount collected per visit (59).
Complication of Pregnancy	Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or fetus. Morning sickness and a non-emergency caesarean section generally are not considered complications of pregnancy (62).
Contractual Adjustment	Amount of charges a provider or hospital agrees to write off and not charge the patient per the contract terms with the insurance company (59).
Coordination of Benefits (COB)	When a patient is covered by more than one insurance plan. One insurance carrier is designated as the primary carrier and the other as secondary (62).
Co-payment	Fixed amount an individual patient pays for a health care service otherwise covered by their third-party insurance payor. This is often paid (or billed to the patient) upon the receipt of services. Co-pays are different than deductibles and the amount can vary by the type of covered health care service (59).
Cost-Sharing	Involves a patient share of costs for services that a plan covers that the patient must pay out of their own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are co-payments, deductibles, and co-insurance. Family cost-sharing is the share of cost for deductibles and out-of-pocket costs the patient and their spouse and/or child(ren) must pay out of their own pocket. Other costs, including premiums, penalties, or the cost of care a plan does not cover are usually not considered cost-sharing (59).
Cost-Sharing Reductions	Discounts that reduce the amount the patient pays for certain services covered by an individual plan purchased through the Marketplace. The patient may get a discount if their income is below a certain level, if the patient chooses a Silver level health plan, or if they are a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation (62).
Covered Benefit	A health service or item that is included in your health plan, paid for either partially or fully. Covered benefits and excluded services are defined in the health insurance plan's coverage documents (62).

Credentialing	Application process for a provider to participate with an insurance carrier. Many carriers now request credentialing through the Council of Affordable Quality Healthcare (CAQH), which is a universal system now accepted by insurance company networks (62).
Credit Balance	Balance shown in the "Balance" or "Amount Due" column of the account statement with a minus sign after the amount (e.g. $50-). It may also be shown in parenthesis: ($50). The provider may owe the patient a refund (59).
Crossover Claim	When claim information is automatically sent from Medicare to the secondary insurance, such as Medicaid (59).
Current Ratio	This liquidity indicator shows the number of times short-term obligations can be met from short-term creditors. Because it provides an indication of the ability to pay liabilities, a high ratio number is one-way short-term creditors evaluate their margin of safety. Formula: total current assets ÷ total current liabilities (59).
Cushion Ratio	A measure of the capital structure of the organization. This ratio is important in evaluating the financial risk position of an organization. Formula: (cash and cash equivalents + board-designated funds for capital) ÷ estimated future peak debt service (59).
Date of Service (DOS)	Date that health care services were provided. For visits in which care crosses midnight, this is the date the visit was initiated (61).
Day Sheet	Summary of daily patient treatments, charges, and payments received (61).
Days in Accounts Receivable	The average number of days it takes to collect an account receivable. Since the days' sales in accounts receivable is an average, you need to be careful when using it. This is also referred to as the number of days receivables (59).
Debt Service Coverage Ratio	Metric used to measure an organization’s cash flow available to pay current debt obligations. It is a ratio of net operating income to debt obligations within 1 year, including interest principal, singing-fun, and lease payments. Formula: net revenue available for debt service ÷ (principal payment + interest expense) (59).
Debt-to-Capitalization (%)	Measure of a company’s total outstanding debt as a percentage of a company’s total capitalization. Formula: (short-term debt + long-term debt) ÷ (short-term debt + long-term debt + [income + assets]) (66).
Deductible	In health insurance, a deductible is the amount that a policyholder must pay each coverage period toward medical expenses before the insurance company begins to pay its share.
Discount	Prospective reduction to a patient's bill, usually due to a prearranged contractual agreement between a hospital or doctor and the payor, typically an insurance company. A discount is typically either a fixed amount or a percentage reduction in the charge for a specific CPT code, procedure, or diagnosis (61).
Duplicate Coverage Inquiry (DCI)	Request to an insurance company or group medical plan from another insurance company or medical plan to determine if other coverage exists (59).
Durable Medical Equipment (DME)	Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include oxygen equipment, wheelchairs, crutches, etc. (59).

Earnings Before Interest, Taxes, Depreciation, and Amortization (EBITDA)	Measure of a company's operating performance calculated by adding non-cash expenses related to depreciation and amortization (paid debt) to a firm's operating income. An alternative way to calculate EBITDA is to start with a company's net income and add back interest, taxes, depreciation, and amortization. Formula: Earnings Before Interest and Tax + Depreciation + Amortization (67).
Electronic Claim	When an insurance claim requesting payment for delivered healthcare services is sent electronically from the billing software of the healthcare organization to an insurance clearinghouse or directly to the insurance carrier. The claim file must be in a standard electronic format as defined by the receiver (59).
Electronic Remittance Advice (ERA)	Explanation of a medical insurance claim's payment status that is made available from the electronic data interchange (EDI) used for sending insurance billing claims. If denied by the insurer, it will include the rationale. This is an electronic version of the Explanation of Benefits (EOB) that is sent to a patient (59).
ED Reimbursement Model	The model an ED uses to obtain reimbursement from payor(s) for services provided. Examples include fee-for-service, capitation, gain sharing, value-based reimbursement, or accountable care organization payments. These payments may be from insurance payors or alternative state or federal government-subsidized payment programs (68).
Emergency Medical Condition (EMC)	An emergency medical condition is defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part (40).
Employee Retirement Income Security Act (ERISA)	This federal law, passed in 1974, established the reporting, disclosure of grievances, and appeals requirements and financial standards for group life and health insurance policies. Self-insured plans are regulated by this law (59).
Errors and Omissions Insurance	Liability insurance for professionals to cover mistakes that may cause financial harm to another party. It generally includes coverage for court costs and any settlement payments up to the coverage amount (59).
Evaluation and Management (E/M)	E/M coding is the process by which physician-patient encounters are translated into five-digit CPT codes to facilitate billing. The E/M codes used for Emergency Medicine include CPT codes 99201 thru 99499 (62,68,69).
Excess Margin (%)	This is a measure of an organization's profitability. It includes the revenue left over after the cost of services delivered are subtracted (operating margin), but also includes all other sources of income (donations, endowments, etc.) and other expenses incurred by the organization (59).
Explanation of Benefits (EOB)	A notice received by a patient from their insurance company after receiving medical services from a healthcare provider or organization that details what was billed, the payment amount approved by the insurer, the amount paid by the insurer, and the amount the patient is obligated to pay. For Medicare this is referred to as a Medicare Summary Notice (MSN) (61).
Fee for Service	A type of insurance plan in which the provider is paid for each service or procedure provided. These plans typically allow the insured to choose their

	provider or healthcare organization. Some policies require the patient to pay the provider directly for services and submit a claim to the carrier for reimbursement. The trade-off for this flexibility is usually higher deductibles and co-pays (59).
Fiscal Intermediary (FI)	A Medicare representative who processes Medicare claims that have been submitted for reimbursement (59).
Group Health Plan (GHP)	When a group of beneficiaries from one or more employers receives medical care insurance for the beneficiaries or their dependents directly or through insurance, reimbursement, or otherwise (62,70).
Gross Collection Ratio	The total payments received by a health provider or healthcare organization over a specific period divided by the total charges without write-offs. It is influenced by how a provider or organization practice sets its fee schedules. When fee schedules are set at a much higher rate than reimbursement allowances, the gross collection rate is low. Many third-party contracts with low reimbursement rates will also affect the ratio, and a greater proportion of Medicaid patients will lower the ratio as well. Formula: Payments ÷ Charges. (59,71)
Gross Margin	Indicates how much profit a company makes after paying off all costs related to providing services. It is a measure of a company's efficiency in using its equipment, facilities, and labor to deliver services for profit. The higher the profit margin, the more efficient the company (62).
Guarantor	Also known as the "responsible person," this is the person who is held financially responsible for an insured individual's medical bill. The guarantor is the patient unless the patient is a minor or incapacitated adult. This is not always the insurance subscriber, spouse, or head of household (59).
Health Care Financing Administration (HCFA)	Now known as the Center for Medicare and Medicaid Services (CMS). See definition above (59).
HealthCare Common Procedure Coding System (HCPCS)	The HCPCS is one of several code systems used by healthcare professionals, including medical coders and billers, to manage healthcare claims consistently and with a shared language. The code system includes three levels described here. The Level I HCPCS code set includes CPT codes developed by the American Medical Association (see definition above). Level II codes are alphanumeric and primarily include non-physician services, such as ambulance services and prosthetic devices, and represent items and supplies and non-physician services not covered by CPT codes (Level I). Level III codes, also called local codes, were developed by state Medicaid agencies, Medicare contractors, and private insurers for use in specific programs and jurisdictions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructed CMS to adopt a standard coding system for reporting medical transactions. The use of Level III codes was discontinued on December 31, 2003 in order to adhere to consistent coding standards (59,72)
Healthcare.gov	HealthCare.gov is a health insurance exchange website operated by the US Federal Government under the provisions of the ACA. The exchange facilitates the sale of private health insurance plans to residents of the US and offers subsidies to those who earn between one to four times the federal poverty line. Those making less than the federal poverty line are directed to Medicaid

	options. In addition, there is a separate marketplace for small businesses to acquire insurance plans for their employees (73).
Health Care Reform Act	A law enacted in March 2010 commonly called the ACA, Obamacare, or Patient Protection and Affordable Care Act (see definition for the ACA above) (58).
Health Savings Account (HAS)	A type of savings account that lets individuals set aside money on a pre-tax basis to pay for qualified medical expenses. HSA funds may be used to pay for deductibles, copayments, coinsurance, and some other expenses. Generally, they may not be used to pay premiums. They differ from Flexible Spending Accounts in that the allocated funds carry over from year to year (62).
Healthcare Insurance	Insurance coverage to cover the cost of medical care necessary as a result of illness or injury. It can be an individual policy or family policy that covers the beneficiary's family members. It also may include coverage for disability or accidental death or dismemberment (62).
Health Insurance Claim (HIC)	This is a number assigned by the Social Security Administration to a person to identify them as a Medicare beneficiary. This unique number is used when processing Medicare claims (59).
Health Insurance Portability and Accountability Act (HIPAA)	HIPAA was passed by Congress in 1996 and targets four main areas: 1) it provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs; 2) it establishes rules to reduces health care fraud and abuse; 3) it mandates industry-wide standards for health care information on electronic billing and other processes; and 4) it sets requirements for the protection and confidential handling of protected health information(74,75).
HMO (Health Maintenance Organization)	An HMO is a type of health insurance plan that aims to achieve lower costs for services and coverage by restricting approved providers to a defined network of affiliated doctors, hospitals, and other healthcare providers. These providers agree to accept payment at a certain level of reimbursement per patient, regardless of the cost of health care delivered (59,76).
Home Health Care	This includes a wide range of health care services that can be given in your home for an illness or injury. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning, or driving (59,77)
Hospital-Based Care	Patient care that involves the delivery of medical services, including monitoring, diagnostics, interventions, therapies, and resources typically administered in a structured, coordinated, team-based hospital setting. This can include ED, ED observation, in-hospital observation or in-hospital inpatient care.
Hospital Reimbursement Model	Model a hospital uses to obtain reimbursement from payor(s) for services provided. Examples include fee-for-service, capitation, gain sharing, value-based reimbursement, or accountable care organization payments. These payments may be from insurance payors or alternative state or federal government subsidized payment programs.
International Classification of Diseases (ICD) Code	The ICD coding system is used to assign codes to patient diagnoses, procedures, and tests. This is a three- to seven-digit alphanumeric code. It includes additional digits to allow more available codes. The U.S. Department

	of Health and Human Services transitioned from using the 9th version (ICD-9) to the 10th version (ICD-10) in October of 2015 (62).
Incremental Nursing Charge	These are charges for hospital nursing services that are in addition to basic room and board or facilities fees (59).
Indemnity	This is a type of commercial health insurance plan, also referred to as fee-for-service, in which the patient can use any provider or hospital without network limitations. Medical bills are then sent to the insurance company, who pays a portion of the cost 590).
In-Network Co-insurance	This is the percentage of the charges for a patient's healthcare costs their insurance plan will pay (the allowed amount, see definition above) that the patient is responsible to pay for in-network covered services. This is usually lower than out-of-network co-insurance (59).
In-Network Copayment	A fixed amount a patient pays for covered health care services to providers who contract with the patient's health insurance or plan. In-network copayments are usually less than out-of-network copayments (62).
Independent Practice Association (IPA)	An organization of physicians that negotiate contracts with managed care organizations for a negotiated per capita rate, flat retainer fee, or fee-for-service basis (62,78).
Medicare Administrative Contractor (MAC)	A private health care insurer that has been awarded geographic jurisdiction to process Medicare Part A & Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries (79).
Managed Care Plan	An insurance plan requiring a patient to see doctors and hospitals that are contracted with the managed care insurance company. Typically, medical emergencies or urgent care are exceptions for when medical care provided outside of the managed care plan service area may be covered (59).
Marketplace	Often refers to the Health Insurance Marketplace created as a result of the 2010 ACA (see definitions above) to present individuals, families, and small businesses with comparative information online, via telephone, and in person. Its information structure enables the comparison of plan options based on cost and coverage features, eligibility screening for financial support with premiums, the ability to enroll for coverage, and (in some states) enrollment in other government programs. This interface and resource is also known as "The Exchange." Depending on the state, it may be managed by the state vs. the federal government (80).
Medically Necessary	Health care service or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms, including habilitation, and which meets accepted standards of medicine (81).
Medicare	A federal health insurance program for people age 65 and older. Medicare covers some people under age 65 who have disabilities or end-stage renal disease (ESRD). The original program is referred to as Medicare Part A and covers inpatient care in hospitals and hospices, as well as some skilled nursing costs. It is often referred to as Medicare Hospital Insurance. Medicare Part B helps pay for doctor services, outpatient care, and other medical services not paid for by Medicare Part A. Medicare Part C is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. These are often called

	Medicare Advantage Plans. Medicare Part D was added in 2003 to include optional supplemental prescription drug plans (PDPs) that add medication coverage to Original Medicare (Part A and B), some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans (59).
Medicare Co-insurance Days	Original Medicare covers up to 90 days of inpatient hospital care each benefit period. The first 60 days have no co-insurance for the patient. Days 61-90 are associated with a co-insurance fee ($341/day in 2019). After day 90, there are an additional 60 days of coverage, called lifetime reserve days. These 60 days can be used only once and require the patient pay a higher co-insurance ($682/day in 2019) (82,83).
Net Collection Ratio	A term used in medical accounting to describe the amount of money collected on the agreed-upon fees charged. Net collections are usually lower than net charges (the total amount the provider agrees to accept as payment) and are certainly lower than gross charges (the provider's total invoice amounts before insurance adjustments and other adjustments). The net collection ratio is calculated by dividing payments received from insurers and patients by payments agreed upon with insurers and patients. A medical practice reports its net collections on the income statement, along with gross charges, net charges, and the gross collection rate. Formula: payments received from insurers and patients ÷ payments agreed upon with insurers and patients (59).
Net Contribution Margin	Net sales minus the variable product costs and the variable period expenses. In accounting, the net contribution margin is defined as revenues minus variable expenses. In other words, the contribution margin reveals how much of a company's revenues (after covering the variable expenses) will be contributing to the company's fixed expenses and net income. The contribution margin can be presented as: 1) the total amount for the company, 2) the amount for each product line, 3) the amount for a single unit of product, and 4) as a ratio or percentage of net sales (59).
Net Income	This is the bottom line of the income statement. It is the mathematical result of revenues and gains minus the cost of goods sold and all expenses and losses (including income tax expense if the company is a regular corporation), provided the result is a positive amount. If the net amount is a negative amount, it is referred to as a net loss (84).
Network	The facilities, providers, and suppliers with which a health insurer or plan has contracted to provide health care services that are eligible for reimbursement (85).
Office of the Inspector General (OIG)	Part of the US Department of Health and Human Services. It established and maintains compliance requirements to combat healthcare fraud and abuse. It has guidelines for billing services and individual and small group physician practices (59).
Operating Margin (%)	This profitability indicator shows the income derived from patient care operations. Profitability indicators measure the extent to which the organization is using its financial and physical assets to generate a profit (59).
Out-of-Network Provider (Non-preferred Provider)	A provider who does not have a contract with your plan to provide services. If a patient's plan covers out-of-network services, the patient will usually pay

	more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network” provider (62).
Out-of-Pocket Cost	Expenses for medical care paid by a patient that are not reimbursed by insurance. Out-of-pocket costs include deductibles, co-insurance, and co-payments for covered services, plus any other services that are not covered (61).
Place of Service	A two-digit code on medical insurance claims - such as the CMS 1500 block 24B – that defines where the procedure was performed. (i.e. - 11 = doctor’s office, 12 = home, 21 = inpatient hospital, 23 = emergency room hospital) (62).
Point-of-Service (POS) Plan	A flexible type of HMO plan in which patients have the freedom to use (or self-refer to) non-HMO network providers but may pay a higher deductible and percentage of the co-insurance (62).
Preferred Provider Organization (PPO)	Commercial insurance plan in which the patient can use any doctor or hospital within the network (similar to an HMO) for a reduced fee. However, they often have less favorable coverage of visits with a wider range of providers at a higher cost (59).
Proprietary Laboratory Analyses (PLA) Codes	CPT codes that were defined and added under the Protecting Access to Medicare Act of 2014 and describe proprietary clinical laboratory analyses. These can be provided by a single laboratory that is a sole source for a test or shared by multiple laboratories that are cleared by the Food and Drug Administration (FDA). These include Advance Diagnostic Laboratory Tests (ADLTs) and Clinical Diagnostic Laboratory Tests (CDLTs), amongst others (63).
Provider Fee Schedule (Charge Master)	List of charges for each CPT code for a provider’s evaluation, treatment, or other services. This is differentiated from a Payor’s fee schedule, which includes what the insurance company will pay (86).
Prudent Layperson Standard	This law requires an insurance company to cover a visit based on the patient’s symptoms, not the final diagnosis. Specifically, it notes that a medical condition is to be considered emergent by the manifestation of acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (87,88,89,90).
Remittance Advice (R/A)	A document supplied by the insurance payor with information on claims submitted to them for payment. It contains explanations for rejected or denied claims. It is also referred to as an EOB (see above for definition). An electronic version is referred to as an ERA (see definition above) (62).
Revenue Code	The three-digit number used on hospital bills to tell the insurer the type of hospital treatment location the patient was in when they received treatment, or what type of item of care a patient received. The ED location revenue code is typically 450 (59).
Relative Value Unit (RVU)	RVUs are a measure of value in the US Medicare reimbursement formula for physician services as a component of the resource-based relative value scale

	(RBRVS). The number of RVUs is typically multiplied by a conversion factor (payment per RVU) to determine reimbursement rates (59).
Scrubbing	Process of checking an insurance claim for errors in the health insurance claim software prior to submitting to the payor (59).
Secondary Insurance	Extra insurance that may pay some charges not paid by your primary insurance company. Whether payment is made depends on your insurance benefits, your coverage, and your benefit coordination (59).
Subscriber	Describes the employer for group policies. For individual policies, the subscriber describes the policyholder (62).
Superbill	A superbill is an itemized form that details healthcare services provided to a patient. It is the main data source used to create a claim submitted to payors (insurances, funds, programs, etc.) for payment/reimbursement (62).
TRICARE	This is a federal health insurance plan for active duty military, National Guard and Reserve, retirees, their families, and survivors. Formerly known as CHAMPUS (59).
UB04	The UB04 form was created by the CMS to be used by providers and healthcare organizations for billing claims. It replaced a previously used UB92 form and has become the most commonly used form for medical and mental health claims submissions across all insurance carriers. It is commonly known by its white paper with red ink (59).
Unbundling	Submitting several CPT treatment codes when only one code is necessary (59).
Usual, Customary, and Reasonable (UCR)	The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount is sometimes used to determine the allowed amount (91).
Utilization Limit	Limit that Medicare sets on how many times certain services can be provided for a patient within a year. The patient's claim can be denied if services provided exceed this limit (59).
Utilization Review (UR)	A review or audit conducted to reduce unnecessary inpatient or outpatient medical services or procedures (59).
V-Codes	An ICD clinical modification (CM) set of codes for health care provided for reasons other than injury or illness (59).
Workers Compensation	This is a form of accident insurance paid by employers to pay healthcare claims filed for medical care that addresses work-related injury or illness (59,92).
Write-off	A retrospective reduction in a charge for medical services. This typically refers to the difference between what the physician charges and an agreed-upon lesser amount received (93).

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