113th: The one hundred thirteenth Congress is the current meeting of Congress (the Senate and the House of Representatives). It convened on January 3, 2013, and will run through January 3, 2015.

ABN: Advanced Beneficiary Notice is a written notice to Medicare patients notifying them that Medicare may deny payment for that specific procedure or treatment, and the patient may be personally responsible for full payment if Medicare denies payment.

ACMUI: The Advisory Committee on the Medical Uses of Isotopes advises NRC on policy and technical issues that arise in the regulation of the medical uses of radioactive material in diagnosis and therapy. See NRC.

Amendment: A change made to a pending motion or bill, or a previously adopted law or motion.

APC: All services paid under the hospital outpatient prospective payment system are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC.

Approps: The Committee on Appropriations in both the Senate and House. These committees have jurisdiction over all discretionary spending legislation in their respective chambers. See discretionary spending; ranking member.

ASC: An ambulatory surgical center is a facility that provides surgical services as approved by Medicare. Medicare has established a separate payment system for these sites based on 65 percent of the payment under the hospital outpatient prospective payment system.

Category I CPT code: Category I CPT codes describe a procedure or service identified with a five-digit CPT code and a descriptor for that code. The descriptor for the Category I CPT is based on contemporary medical practices being performed by many clinical physicians in multiple locations across the U.S.

Category II CPT code: Category II CPT codes are supplemental tracking codes that can be used for performance measurement.

Category III CPT code: Category III CPT codes are used for new and emerging technologies and are temporary codes.
CBO: The Congressional Budget Office is a nonpartisan federal agency that provides economic forecasts to Congress, including estimates of the impact of legislation on the federal budget, known as “scores.” See score.

CF: The Medicare conversion factor is a dollar multiplier that converts the geographically adjusted number of relative value units (RVUs) or APCs for each service in the Medicare physician fee schedule and hospital outpatient prospective payment system into a dollar payment amount. See APC.

Chief: Abbreviation for chief of staff. A top congressional staffer who has overall political and office supervision responsibility.

Cloture: A vote taken to end debate in the Senate (60 votes are needed for approval). Cloture is the only procedure by which the Senate can vote to place a time limit on debate to overcome a filibuster. See filibuster.

CMS: The Centers for Medicare and Medicaid Services is a federal agency within the HHS that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program and health insurance portability standards. See HHS.

CMMI: The Centers for Medicare and Medicaid Innovation with CMS supports the development and testing of innovative health care payment and service delivery models.

CED: Under Coverage with Evidence Development, CMS or other payers agree to cover new medical technologies provided that patients who receive care using those technologies are enrolled in a clinical study to generate the additional benefit and safety information needed to make an informed coverage decision.

CPT: Current Procedural Terminology refers to the terms and identifying codes that provide a uniform language to accurately describe medical, surgical and diagnostic services.

CPT Advisory Panel: The members of this committee are primarily physicians nominated by the national medical specialty societies represented in the AMA House of Delegates. ASTRO has a representative on this committee. The primary objective of this committee is to serve as a resource to the CPT Editorial Panel by giving advice on procedure coding and appropriate nomenclature as relevant to the member’s specialty.

CPT Editorial Panel: Run by the AMA, this panel and it is responsible for maintaining, revising, updating or modifying the CPT code set. The panel itself has 17 members. Of those, 11 are physicians nominated by their national medical specialty societies and approved by the American Medical Association Board of Trustees.
**CR:** A continuing resolution is a bill used to fund government agencies at current levels if an appropriations bill has not been signed into law by the end of the fiscal year.

**Dear Colleague:** A letter sent from one or more members of Congress to other members of Congress usually calling their attention to an issue and urging their support or opposition.

**Discretionary spending:** Spending set by an annual appropriations process to fund various activities (e.g., military, transportation, NIH) made by decisions of Congress. This spending is optional and separate from mandatory funding for entitlement programs. See NIH.

**E/M:** Evaluation and Management services are patient evaluation and management services that a physician provides during a patient’s office, hospital, or other visit or consultation. Thus method is based on type or history, examination and medical decision making.

**Energy and Commerce:** Refers to the House Committee on Energy and Commerce, which has jurisdiction over public health; mental health and research; biomedical programs and health protection in general, including Medicaid and national health insurance; and food and drugs. The committee is chaired by Republican Fred Upton of Michigan, and the ranking member is Democrat Henry Waxman of California.

**FDA:** The Food and Drug Administration is a federal agency within HHS that is responsible for protecting and promoting public health through the regulation and supervision of food safety, tobacco products, prescription and over-the-counter pharmaceutical drugs, vaccines, biopharmaceuticals, and medical devices. See HHS.

**Federal Register:** The official journal of the federal government that contains most routine publications and public notices of government agencies. The daily publication also includes proposed and revised rules and regulations. See proposed rule; final rule.

**Filibuster:** A senate rule that permits a senator, or a series of senators, to speak for as long as they wish on any topic they choose. Invoking cloture is the only way to end a filibuster. House rules do not permit filibusters. See cloture.

**Final Rule:** A regulation that has gone through the review and public comment process. Final rules are published with an effective date of when they become law.

**Finance:** Refers to the Senate Committee on Finance, which has jurisdiction over health programs under the Social Security Act (notably Medicare and Medicaid) and health programs financed by a specific tax or trust fund. The committee is chaired by Democrat Max Baucus of Montana, and the ranking member is Republican Orrin Hatch of Utah.
Fly-in: Also referred to as a “lobby day,” this is an organized event that brings groups of constituents to Washington, D.C., to meet their members of Congress and discuss issues affecting their lives or industry. ASTRO’s Advocacy Day is a fly-in.

GAO: The Government Accountability Office is the audit, evaluation and investigative arm of the U.S. Congress. GAO is currently investigating self-referral in radiation oncology with a report expected in the spring of 2013.

GPCIs: The Medicare physician fee schedule pricing amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index has been established for every Medicare payment locality for each of the three components of a procedure’s relative value unit (i.e., the RVUs for work, practice expense, and malpractice).

Grassroots/Grasstops: Any activity driven by the constituents of a community, as opposed to being organized by central power structures. One example of a grassroots activity is a citizen calling or writing his or her member of Congress about an issue. Grasstops is also activity on the community level but it is generally driven by local leaders of the community. One example of grasstops activity is a local elected official or prominent member of the community submitting an op-ed on an issue to a newspaper.

Health sub: An abbreviation for health subcommittee. Both the House Energy and Commerce Committee and Ways and Means Committee have health subcommittees.

HHS: The U.S. Department of Health and Human Services is tasked with protecting the health of all Americans and providing essential human services. Its agencies include CMS, FDA and NIH among others. See CMS, FDA and NIH.

HOPPS: Hospital Outpatient Prospective Payment System refers to section 4523 of the Balanced Budget Act of 1997 which provides authority for CMS to implement a prospective payment system under Medicare for hospital outpatient services, certain Part B services furnished to hospital inpatients that have no Part A coverage and partial hospitalization services furnished by community mental health centers.

ICD-9: ICD-9 is an acronym used in the medical field that stands for International Classification of Diseases, ninth revision. The ICD is used to provide information on a claim about the patient’s signs, symptoms and/or diagnosis.

LA: A legislative assistant is a congressional staffer who monitors pending legislation, conducts research, drafts legislation, gives advice and counsel and makes recommendations to the member of Congress. Members of Congress have multiple legislative assistants who may be tasked to handle one or more issue areas.

LC: A legislative correspondent is a congressional staffer who is responsible for supporting the legislative assistants and responding to the mail received by a member of Congress.
LCD: Local Coverage Determinations were established by the Benefits Improvement and Protection Act for Medicare, and is a decision by a local Medicare contractor whether to cover a particular medical service based on whether the service is reasonable and necessary.

LD: The legislative director is a congressional staffer who oversees the legislative assistants and legislative correspondents, monitors the legislative schedule and makes recommendations.

Malpractice RVUs: Malpractice relative value units represent payment for the professional liability expenses.

Mark up: The process by which a congressional committee debates, amends and rewrites proposed legislation.

MDUFMA or MDUFA: The Medical Device User Fee and Modernization Act of 2002 was enacted to provide the FDA with the resources necessary to better review medical devices, to enact needed regulatory reforms so that medical device manufacturers can bring their safe and effective devices to market, and to ensure that reprocessed medical devices are as safe and effective as original devices. Congressional authorization of the Medical Device User Fee Program is needed every 5 years, and was last renewed in 2012.

Meaningful Use: Meaningful use is the set of standards defined by the Medicare and Medicaid Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria.

MedCAC: The Medicare Evidence Development and Coverage Advisory Committee was established to provide independent guidance and expert advice to CMS on specific clinical topics. The MedCAC reviews and evaluates medical literature, technology assessments, and examines data and information on the effectiveness and appropriateness of medical items and services that are covered under Medicare, or that may be eligible for coverage under Medicare.

MedPAC: The Medicare Payment Advisory Commission is an independent federal body tasked with advising Congress on issues affecting the administration of the Medicare program. The commission produces two major reports to Congress each year that contain recommendations to improve the Medicare program.

MEI: Medicare Economic Index is an index introduced in 1976 that is intended to measure the annual growth in physicians’ practice costs and general inflation in the cost of operation a medical practice.

MPFS: The Medicare Physician Fee Schedule relates payment for physician work and practice expenses to the actual resources used to provide medical services rather than physicians’ historical charges. The MPFS is updated annually.
MPPR: A multiple procedure payment reduction. Medicare has a longstanding policy to reduce payment for the second and subsequent surgical procedures furnished to the same patient by the same physician on the same day, largely based on the presence of efficiencies in the PE and pre- and post-surgical physician work. This is referred to as the MPPR policy. In 1995 this policy was extended to several nuclear medicine diagnostic procedures. In 2006 this policy was again extended to the technical component of certain diagnostic imaging procedures. It currently does not apply to radiation therapy services. See PE RVUs

NCI: The National Cancer Institute is part of the NIH. The NCI coordinates the U.S. National Cancer Program and conducts and supports research, training, health information dissemination and other activities related to the causes, prevention, diagnosis and treatment of cancer; the supportive care of cancer patients and their families; and cancer survivorship. See NIH.

NCCI: The National Correct Coding Initiative was developed by CMS to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CCI edits identify sets of CPT codes that cannot be billed together and MUE edits indicate the number of times a CPT code can be billed. See CMS, CPT codes, MUE.

NCD: National Coverage Determination is Medicare’s nationwide decision process to determine which select medical items or services may be eligible for coverage under the Medicare program. These decisions are made through an evidence based process, with input from MedCAC and opportunities for public participation. See MedCAC

NIH: The National Institutes of Health is a federal agency within the HHS and is the primary agency of the U.S. government responsible for biomedical and health-related research. It consists of 27 separate institutes and offices, including the NCI. See HHS, NCI.

NRC: The Nuclear Regulatory Commission is a government agency that regulates the nation’s civilian use of byproduct, source and special nuclear materials to ensure adequate protection of public health and safety, to promote the common defense and security, and to protect the environment.

OIG: The Office of Inspector General investigates criminal activity for HHS. The special agents who work for OIG have the same authority as other federal criminal investigators, such as the FBI. However, OIG special agents have special skills in investigating white collar crime related to Medicare and Medicaid fraud and abuse. See HHS.

Omnibus bill: A single bill that packages together several measures or combines diverse subjects.

PAC: A political action committee is a group, regardless of size, organized to elect political candidates or to advance the outcome of a political issue or legislation. ASTRO has a PAC. Reminder: It is illegal to discuss political fundraising in official government buildings, including House and Senate office buildings.
**Payfor**: A spending offset for a piece of legislation, which is necessary under PAYGO budgeting. See **PAYGO**.

**PAYGO**: Short for “pay as you go,” it is the practice of financing new expenditures with funds that are currently available (or with cuts to other existing programs).

**PC**: The professional component is the payment for physician services used to provide all medical services in the Medicare program in all practice settings. The professional component is based on three components which are physician work, indirect practice expenses and malpractice expense.

**PE RVUs**: Practice Expense Relative Value Units represent the resources used in furnishing supplies, office rent/lease, equipment and personnel wages (excluding malpractice expense) when providing physician services.

**Physician Work RVUs**: The relative level of physician time, skill, training and intensity to provide a given service.

**PPACA**: The Patient Protection and Affordable Care Act is the formal name of the 2010 health reform legislation. It is also commonly referred to as the Affordable Care Act (ACA).

**PPS**: The Prospective Payment System is a method of reimbursement in which Medicare payment is made based on previous year’s data to determine the current year’s payment rates.

**PQRS**: The Physician Quality Reporting System, previously known as Physician Quality Reporting Initiative (PQRI), was established by the 2006 Tax Relief and Health Care Act (TRHCA). It required the establishment of a physician quality reporting system including incentive payments for those who satisfactorily report data and quality.

**Proposed Rule**: A regulation published by an executive branch department or administrative agency in the Federal Register for review and public comment prior to its adoption. Proposed rules do not have the force of law. See **Federal Register**.

**Ranking member**: The most senior member of a committee or subcommittee from the minority party.

**Reconciliation**: A legislative process intended to allow consideration of a contentious budget bill with debate limited to 20 hours in the Senate. Reconciliation also exists in the House, but because the House regularly passes rules that constrain debate and amendments, the process has a less significant impact on that body.

**Regular order**: When both the House and Senate abide by their standing rules (i.e., members are allowed to offer amendments to legislation, complete their budgets on time, both the House and Senate convene in formal conferences to reconcile legislation).
**Rider:** A clause added to a bill having little to do with the subject matter of the bill.

**RBRVS:** The Resource-Based Relative Value Scale assigns procedures performed by a physician or other medical provider a relative value which is based in relativity to one base code in the Medicare Physician Fee Schedule. There are separate relative values for physician work practice expense and malpractice value for both physicians and practice expenditures in the office setting.

**ROBM:** Radiation Oncology Benefit Managers are private organizations that manage the pre-authorization of radiation oncology services for various private payers in an attempt to control costs.

**RUC:** The AMA/Specialty Society Relative Value Scale Update Committee is an expert panel that develops physician work relative value recommendations and recommendations for direct practice expense inputs to CMS for the Medicare physician fee schedule.

**RVUs:** Medicare uses a physician fee schedule to determine payments for over 7,000 physician services. The fee for each service depends on its relative value units, which rank on a common scale the resources used to provide each service. These resources include the physician’s work, the expenses of the physician’s practice and professional liability insurance. To determine the Medicare fee, a service’s RVUs are multiplied by a dollar conversion factor.

**Score:** An official cost estimate of legislation from the CBO. See CBO.

**Sequestration:** Across-the-board spending cuts. As a consequence of Congress being unable to compromise during the “super committee”, a sequester was enacted under the Budget Control Act of 2011 to begin on January 2, 2013. On March 1, President Obama signed an order authorizing the government to cut $85 billion from federal spending, including a 2 percent cut to Medicare physician payments.

**SGR:** The sustainable growth rate is the formula that Medicare uses to calculate physicians’ fees.

**TC:** The technical component represents the cost of clinical time, equipment and supplies to perform that service or procedure. This modifier corresponds to the equipment/office setting part of a given service or procedure.

**Think tank:** Organization involved in policy advocacy and research.

**Value Based Payment Modifier:** Section 3007 of the Affordable Care Act mandated that, by 2015, CMS begin applying a value modifier under the Medicare Physician Fee Schedule. Both cost and quality data are to be included in calculating payments for physicians. See MPFS.

**Ways and Means:** Refers to the House Committee on Ways and Means, which has jurisdiction over programs providing payments (from any source) for health care, health delivery systems and health
research. The committee is chaired by Republican Dave Camp of Michigan, and the ranking member is Democrat Sander Levin of Michigan.

**Wonk**: Expert who studies a subject or issue thoroughly or excessively; associated with "policy wonk."