

HEALTH CARE LINGO

Health care has a language of its own. Medical jargon and hospital terms can mean little or nothing to an outsider. Jargon is verbal shorthand, convenient for those who know it and confusing for those who don't.

Remember the early days of the space program? Our attempt to put a man on the moon gave us more than TANG. It gave us "A-OK" and terms like extra vehicular activity or space walk. We learned about burn time, splashdowns, command modules and LEMs (dune buggies used on the moon).

Health care jargon is not as dramatic. But learning some of it can help you be a better health care consumer. Your doctor wants you to know the meanings of some words and phrases that you may see or hear frequently.

And if you're still confused, ask your doctor. Your doctor wants you to know.

MEDICARE

Founded in 1965 as part of the Social Security System, Medicare is health insurance for persons 65 and older. Medicare payments are made directly to hospitals and doctors. The federal government sets the amounts Medicare will pay based on a system of diagnosis related groups (DRG's, see below).

MEDICAID

Medicaid is similar to Medicare, but it provides health insurance to qualified, poverty-level Americans. Medicaid is administered by the states with partial funding from the federal government.

DIAGNOSIS RELATED GROUPS

(DRG's) In 1983 Medicare initiated a new system of payment that set maximum payments for each of 467 common diagnoses. Through the DRG formula, hospitals know ahead of time how much they will be paid by the government for each Medicare admission. The DRG system gives hospitals incentives to keep costs down. It also encourages hospitals and doctors to keep days in the hospital to a minimum for Medicare patients. The DRG system is also often called the Medicare Prospective Payment System.

DEDUCTIBLE

A deductible is the amount of money a patient is expected to pay for care before insurance or Medicare coverage applies.

CO-PAY

The percentage of the hospital or doctor bill the patient must pay is called the copay. Co-payments are made in addition to deductibles. For example, many group health plans pay for 80 percent of charges and require the patient to pay 20 percent. The 20 percent is the co-payment.

DISCHARGE PLANNING

This term is usually related to the time when a patient is released from the hospital. At times the patient may not be well enough to return home on his own. Through discharge planning, a service provided by hospitals, proper nursing home care or in-home nursing is arranged. Discharge planners also arrange for needs like wheelchairs, special beds or oxygen.

OUTPATIENT

A term applied to any service that takes place without admission to the hospital, outpatient is the opposite of inpatient. Outpatient services can include surgery, diagnostic tests and therapy. Outpatient services may be offered at a hospital, a doctor's office or any number of free-standing buildings.

PROFESSIONAL REVIEW ORGANIZATION (PRO)

This organization was established by Medicare to evaluate, in advance, the appropriate level of care needed by Medicare patients. The PRO attempts to save Medicare money by limiting inpatient services and recommending outpatient care, or other alternatives, instead. The PRO has the authority to refuse payment for care it deems unnecessary, even if you and your doctor insist otherwise. In such cases you and your doctor can follow the PRO's instructions or pay for the care personally.

HEALTH MAINTENANCE

ORGANIZATION (HMO)

Instead of traditional insurance premiums, members of HMO's pay for their health care through annual membership fees. When hospital or doctor care is needed, there is no additional charge for the medical services. To help keep costs down, HMO's contract with specific hospitals and doctors who agree to supply services at a reduced rate. So, HMO members have a very limited choice of which doctors and which hospitals they will use.

PREFERRED PROVIDER ORGANIZATION (PPO)

Acting like a middle man, negotiating reduced rates from hospitals, doctors and other medical services, the PPO then passes the discounts on to its members. Unlike an HMO, a PPO does not pay for care, it simply refers members to sources of care who have agreed to offer discounts. Like an HMO, a PPO restricts members to a limited number of hospitals and doctors. If a PPO member uses a hospital or doctor not approved by the PPO, the patient pays a higher cost.

OUTPATIENT SURGERY CENTERS

Known by any number of trade or brand names, outpatient surgery centers all offer the same basic service surgery in a non-hospital setting. Prices in such centers are usually less expensive than in-hospital surgery. Unlike hospitals, these centers lack the backup support of trauma teams or

critical care units found in hospitals.

URGENT CARE CENTERS

Urgent care centers are similar to both doctors' offices and hospital emergency rooms, but with significant differences. You can see a qualified physician at an urgent care center, but you may not see the same doctor twice. Your complete medical history may not be readily available from visit to visit. Minor emergencies - broken bones, burns, cuts and temporary illnesses - can be treated in urgent care centers. But since they may lack many of the on-site services of a hospital, they are not intended to handle major trauma or serious injuries.

OUTPATIENT DIAGNOSTIC CENTERS

These services offer x-rays, lab tests and other diagnostic services once found only in hospitals. Doctors send patients to outpatient diagnostic centers with orders to be followed, similar to sending patients to drug stores with prescriptions. Test results are reported to your personal doctor.

SECOND OPINION

Before surgery or major medical procedures, many patients seek second opinions from other doctors. Some insurance plans may require second opinions, even if the patient does not want one. In such required cases, the insurance company pays for the second office visit. Your regular doctor is not offended by

second opinions and will cooperate with the second doctor in sharing your patient records. When second opinions conflict with first opinions, a third doctor's opinion may be required. Again, many insurance plans pay for these additional office visits.

These are but a few of the health care terms a consumer might run into these days. If you're stumped by any new ones, ask your doctor. Your doctor wants you to know.