

RESEARCH ARTICLES

Glossary

Becky Czarnik, Rebecca M. S. Busch, Dana Penilton, Deborah Watkins, Laura Woodard

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The definitions subcommittee was tasked with identifying and defining relevant terms and definitions pertaining to life care plan costing research. However, it became apparent that it was beyond the scope of the Costing Framework Development Project to determine a standard definition for some key terms commonly used by life care planners. A condensed glossary of terms appearing in the chapters which have standard definitions or definitions which have been published in industry journals has been developed. Reaching a consensus on definitions of terms of art in the practice of life care planning would be a good topic for a future Life Care Planning Summit.

Term	Definition
837p / 837i	Standardized electronic healthcare claim file formats used for submitting professional (837p) and institutional (837i) services (Centers for Medicare & Medicaid Services, n.d.).
Aggregated Data	Processed source data compiled into grouped sets by public or commercial systems, used for healthcare pricing and planning.
Associated Costs	This term is found in the 1998 definition of a life care plan and is also used in the Tenets of Life Care Planning published by Paul Deutsch in <i>A Guide to Rehabilitation</i> (Deutsch et al., 2005).
Billed Charges	The charges billed by healthcare providers representing the gross price of services before any discounts or adjustments.
Centers for Medicare & Medicaid Services (CMS)	A federal agency within the U.S. Department of Health and Human Services that administers the nation's major healthcare programs.
Charge	Amount billed for a good or service as published by the provider.
Charge Amount (24F)	Field on the CMS-1500 form indicating the billed amount for the service. Charge information used by databases comes from field 24F.
Chargemaster or Charge Description Master (CDM)	A comprehensive price list maintained by a hospital or provider, including all billable services, procedures, and supplies.
Claim Form CMS-1450 (UB-04)	The standard paper claim form used by hospitals to bill Medicare and Medicaid for facility-based services. Commercial insurance carriers also use this form.
Claim Form CMS-1500	Standard paper claim form used by healthcare providers to bill Medicare carriers and durable medical equipment regional carriers. Commercial insurance carriers also use this form.
Clearinghouse	An intermediary entity that receives, validates, and transmits health care claim information between providers and payers.
Clearinghouse Validation	The process by which a third-party system checks electronic medical claims for format and content errors before submission to payors.
Code of Federal Regulations (CFR)	Sections within the CFR (e.g., 45 CFR 160) that codify legal requirements for healthcare transactions. CFR 38 17.101 is relevant to life care planners because it includes the methodology for the VA Reasonable Charges Data, which is also the data Find-A-Code utilizes for their UCR.
Collateral Source Rule	A legal doctrine that holds if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor (Stern & Owen, 2022).
Commercial Data	A proprietary database maintained by a private vendor containing large

Term	Definition
Repository	volumes of aggregated healthcare cost data.
Current Procedural Terminology (CPT®) code set	a listing of descriptive terms and five-digit codes for reporting medical services and procedures performed by physicians and other qualified health care professionals (American Medical Association, 2026).
Data Repository	Organized systems or platforms that store, aggregate, and maintain health claims and cost-related data such as FAIR Health and Context4Healthcare.
Department of Health and Human Services (HHS)	The U.S. government department overseeing public health, including HIPAA regulation, ICD standard adoption, and data security.
Diagnosis Related Group (DRG)	A classification system used to group hospital services by diagnosis, treatment, and resource use by Medicare and commercial insurance carriers for payment.
Field Locator (FL) Codes	Specific fields on the UB-04 form used to designate types of cost or procedural codes.
HCPCS Codes (Healthcare Common Procedure Coding System)	A set of health care procedure codes used for billing Medicare and Medicaid and by commercial insurance carriers.
HIPAA (Health Insurance Portability and Accountability Act)	A U.S. federal law establishing data privacy and security provisions for safeguarding medical information and standardizing electronic healthcare transactions.
Hospital Price Transparency	The practice of making clear, accessible pricing information about hospital items and services available to the public.
International Classification of Diseases (ICD) Codes	Used for coding diagnoses in U.S. health care settings. Currently Tenth Revision, Clinical Modification (ICD-10-CM)
Invoice	Itemized billing document issued by healthcare providers detailing services rendered and costs.
Jurisdictional Requirements	Legal and regulatory considerations that may influence how life care plans are structured and what they might appropriately include in specific regions.
Medical Cost Database	A structured system for storing and retrieving aggregated cost data for medical procedures, services, and products.
Non-Collateral Aggregated Data	Aggregated cost data that has not been influenced by insurance discounts or contractual arrangements; reflects full-fee costs.
Percentage	A number or ratio expressing a part of a whole as a fraction of 100, using the symbol '%'. Percentage represents proportions, for example 50% meaning 50 out of 100, allowing comparison of parts of different-sized wholes, such as 25% being a quarter of something.
Percentile	A percentile is a position in a distribution of values below which a specified percentage of the values fall. For example, in a distribution of 100 data points, the 70th percentile is the value in the 70th position in the lowest-to-highest array of values. Thus, 70 percent of the values are equal to or lower than the 70th percentile value and 30 percent are equal to or higher than the 70th percentile value (FAIR Health, n.d.).
Procedure Service Code (24D)	Field on the CMS-1500 form representing the medical procedure or service provided.
Public Data Repository	A non-commercial, open-access dataset made available by government or academic institutions for use in healthcare costing and research.
Qualitative Data	Non-numeric information such as narrative responses or meeting notes analyzed for themes and insights.
Quantitative Data	Numeric data that can be used for statistical analysis and interpretation of trends, subject to appropriate analytical limitations.
Raw Claims Data	Unprocessed billing data submitted by providers, typically including diagnosis, procedure codes, charges, and services dates.
Reliability	The degree to which a method gives consistent results.
Role and Function Study	A research study of the knowledge, skills, and activities of a profession or practice.
Self-pay	When a person chooses to pay for hospital or clinic services directly rather than using private health insurance, Medicare, Medicaid, or Workers Compensation. Other common terms include private pay, uninsured, out of pocket, or cash pay.
Source Data	Raw claims data from commercial insurers and public repositories.

Term	Definition
Standards of Practice	A set of professional expectations and ethical responsibilities that guide practitioners in consistent and defensible actions.
UB-04 (Uniform Billing Form)	See Claim Form CMS-1450.
Validity	How accurately a method measures what it is intended to measure.

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