Advanced Certificate in Healthcare Case Management

Legal Aspects of Healthcare Management

A

ABAB (Accredited Business Associate Business) – A designation for entities that have entered into a Business Associate Agreement (BAA) with a covered entity under HIPAA. Related terms: Business Associate, HIPAA. This status indicates compliance with privacy and security standards for handling protected health information (PHI).

Adverse Event – An unintended injury or complication caused by medical management rather than the underlying disease. Related terms: Patient Safety, Root Cause Analysis. Documentation of adverse events is required for reporting to regulatory bodies such as the Joint Commission.

Affirmative Action Plan (AAP) – A written strategy that outlines steps an employer will take to ensure equal employment opportunities for protected classes. Related terms: EEOC, Title VII. In healthcare, AAPs address recruitment, hiring, and promotion practices to prevent discrimination.

Advance Directive – A legal document that specifies a patient's wishes regarding medical treatment when they are unable to communicate. Related terms: Living Will, Durable Power of Attorney for Healthcare. Advance directives must be respected under the Patient Self-Determination Act.

Agency Law – The body of law governing the relationship where one party (the agent) acts on behalf of another (the principal). Related terms: Principal, Fiduciary Duty. In healthcare, physicians often act as agents for hospitals, influencing liability and contractual obligations.

Anti-Kickback Statute (AKS) – A federal law prohibiting the exchange of remuneration for referrals of services covered by federal health programs. Related terms: Stark Law, Corporate Practice of Medicine. Violations can result in criminal penalties and exclusion from federal programs.

Anti-Discrimination Laws – Statutes that prohibit unequal treatment based on protected characteristics. Key examples include Title VI of the Civil Rights Act, the ADA, and the Age Discrimination Act. Related terms: EEOC, Reasonable Accommodation. Healthcare providers must ensure policies and practices are free from bias.

Appeal Process – The procedural steps a patient or provider follows to contest a coverage decision by an insurer. Related terms: External Review, Grievance. Effective appeals require knowledge of contractual language, state statutes, and CMS guidelines.

Arbitration Clause – A contract provision that requires parties to resolve disputes through arbitration rather than litigation. Related terms: Alternative Dispute Resolution (ADR), Mediate. In provider contracts, arbitration clauses can limit exposure to class-action suits.

Arson (Health-Related Context) – The intentional setting of fire that endangers patients or staff. Related

terms: Facility Safety, Risk Management. Hospitals must incorporate fire-prevention policies to comply with NFPA standards and state health codes.

Attorney-Client Privilege – The legal principle that communications between a lawyer and client are confidential. Related terms: Work Product Doctrine, HIPAA. In healthcare litigation, privileged communications may include legal advice on compliance strategies.

Audit Trail – A chronological record of system activity that documents user actions, data access, and modifications. Related terms: Electronic Health Record (EHR), HIPAA Security Rule. Audit trails support forensic investigations and demonstrate compliance during inspections.

Beneficiary – An individual or entity entitled to receive benefits under a health plan or insurance policy. Related terms: Plan Sponsor, Dependent. Accurate identification of beneficiaries is essential for claims processing and COB (Coordination of Benefits).

Beneficiary Designation – The act of naming a person to receive assets or benefits, often used in retirement accounts and life insurance. Related terms: Estate Planning, Trust. Errors in designation can lead to disputes and delayed payouts.

Beneficiary Identification Number (BIN) – A six-digit number used to route pharmacy claims to the correct payer. Related terms: Pharmacy Benefit Manager (PBM), National Provider Identifier (NPI). Correct BIN entry ensures timely reimbursement.

Best-Interest Standard – A legal principle requiring providers to act in the patient's best interest, especially in fiduciary relationships. Related terms: Fiduciary Duty, Informed Consent. Violations can trigger malpractice claims.

Billing Compliance – The set of policies and procedures that ensure accurate, lawful billing practices. Related terms: Fraud and Abuse, Claim Scrubbing. Non-compliance can result in civil monetary penalties under the False Claims Act.

Blue-Button Initiative – A federal program that enables patients to download their health data in a standardized format. Related terms: Interoperability, Patient Access Rule. Facilitates patient-centered care and supports the 21st Century Cures Act.

Board Certification – Formal recognition by a specialty board that a physician has met rigorous standards of education, training, and examination. Related terms: Maintenance of Certification (MOC), Credentialing. Many health systems require board-certified staff for credentialing and privileging.

Board of Directors – The governing body responsible for strategic oversight of a healthcare organization. Related terms: Corporate Governance, Fiduciary Duty. Directors must ensure compliance with statutes such as the ACA and state corporate laws.

Bribery – Offering, giving, receiving, or soliciting something of value to influence a business decision. Related terms: AKS, Foreign Corrupt Practices Act (FCPA). In healthcare, bribery can involve inducements for referrals or device purchases.

Business Associate – An entity that performs functions or activities on behalf of a covered entity that involve PHI. Related terms: HIPAA, Business Associate Agreement (BAA). Business associates must adhere to the same privacy and security standards as covered entities.

Business Associate Agreement (BAA) – A contract that outlines the responsibilities of a business associate to protect PHI. Related terms: HIPAA, Security Rule. Failure to execute a BAA can result in enforcement actions and fines.

C

CAP (Corrective Action Plan) – A structured document outlining steps to remediate compliance deficiencies identified during an audit or inspection. Related terms: Joint Commission Survey, CMS Survey. Effective CAPs include timelines, responsible parties, and measurable outcomes.

CAPTCHA (in Healthcare Portals) – A security tool used to verify that a user is human, preventing automated attacks on patient portals. Related terms: Cybersecurity, HIPAA Security Rule. Proper implementation protects PHI from unauthorized access.

CAPS (Clinical Advancement and Performance System) – A quality improvement framework that integrates evidence-based guidelines into clinical workflows. Related terms: Clinical Pathways, Performance Metrics. Facilitates compliance with CMS quality reporting requirements.

CAR (Corrective Action Request) – A formal request from a regulator or auditor for an organization to correct a specific deficiency. Related terms: CAP, Compliance Audit. Timely response is critical to avoid penalties.

Case Law – Judicial decisions that interpret statutes and establish legal precedents. Related terms: Stare Decisis, Precedent. In healthcare, case law shapes interpretations of informed consent, negligence, and privacy obligations.

Case Management – A collaborative process that assesses, plans, implements, coordinates, and monitors patient care to achieve optimal health outcomes. Related terms: Utilization Review, Care Coordination. Legal aspects include documentation, consent, and adherence to payer policies.

Case Mix Index (CMI) – A relative value assigned to a group of patients that reflects the diversity, clinical complexity, and resource needs of a hospital's case load. Related terms: DRG, Reimbursement. Higher CMI can influence Medicare payments under the Inpatient Prospective Payment System.

Certificate of Need (CON) – A state-issued authorization required for the construction or expansion of certain health facilities. Related terms: Health Planning, Regulatory Review. CON programs aim to control health care costs and avoid service duplication.

CFTC (Consumer Financial Protection Bureau) – While primarily focused on financial products, the CFTC's regulations intersect with health savings accounts (HSAs) and medical credit offerings. Related terms: HSA, Medical Financing.

CHIP (Children's Health Insurance Program) – A federal-state partnership that provides health coverage to

children in families with incomes too high for Medicaid but too low for private insurance. Related terms: Medicaid, Eligibility. Providers must verify CHIP eligibility during enrollment.

CHIPRA (Children's Health Insurance Program Reauthorization Act) – Legislation that introduced quality reporting and preventive services requirements for CHIP. Related terms: Quality Measures, Preventive Care.

CHRONIC Care Management – Ongoing coordination of services for patients with long-term conditions. Related terms: Care Plan, Population Health. Legal considerations include consent for data sharing and adherence to state chronic disease statutes.

Civil Litigation – A legal process in which a plaintiff seeks monetary damages or equitable relief from a defendant. Related terms: Tort, Negligence. In healthcare, civil litigation often involves malpractice claims or breach of privacy.

Clinical Documentation Improvement (CDI) – A program that enhances the accuracy and completeness of clinical records to support appropriate coding and reimbursement. Related terms: DRG Assignment, Compliance.

Clinical Governance – The systematic approach by which organizations are accountable for continuously improving the quality of patient care. Related terms: Quality Assurance, Risk Management.

Clinical Pathway – Evidence-based, multidisciplinary care plans for specific clinical conditions. Related terms: Standard of Care, Utilization Review. Pathways support compliance with CMS's Clinical Care Improvement Programs.

Clinical Trials Regulation (CTR) – A set of EU rules governing the conduct of clinical investigations. Related terms: Informed Consent, IRB. U.S. Equivalents include FDA's 21 CFR Part 50.

Co-Insurance – The percentage of costs a health plan member pays after meeting the deductible. Related terms: Deductible, Out-of-Pocket Maximum.

Co-Payment – A fixed amount a patient pays at the time of service. Related terms: Cost-Sharing, Benefit Design.

COBRA (Consolidated Omnibus Budget Reconciliation Act) – Federal law providing temporary continuation of group health coverage after a qualifying event. Related terms: Qualified Beneficiary, Plan Termination.

Code of Ethics (American Hospital Association) – A set of principles guiding professional conduct in health care. Related terms: Professionalism, Compliance.

Code of Federal Regulations (CFR) – The codified rules published by federal agencies. Relevant titles for health care include Title 42 (Public Health) and Title 45 (Public Welfare). Related terms: Regulatory Compliance, Interpretive Guidance.

Code of Conduct – Internal policies that define acceptable behavior for employees and contractors. Related terms: Ethics Program, Whistleblower Policy.

Code of Federal Regulations (CFR) Title 42 – Contains statutes governing Medicare, Medicaid, and public health. Related terms: CMS, HIPAA.

Code of Federal Regulations (CFR) Title 45 – Includes regulations for HIPAA and the HHS Privacy Rule. Related terms: Privacy Rule, Security Rule.

Code of Professional Conduct (APA) – Guidelines for psychologists, often referenced in behavioral health compliance. Related terms: Confidentiality, Dual Relationships.

Coercion – The practice of forcing a patient to consent to treatment or disclose information against their will. Related terms: Informed Consent, Patient Rights.

Collaboration Agreements – Contracts that define the terms of joint ventures between health systems, physicians, or ancillary service providers. Related terms: Joint Venture, Risk Sharing.

Collective Bargaining Agreement (CBA) – A contract between an employer and a labor union that outlines wages, benefits, and working conditions. Related terms: Labor Law, Union.

Common Law – Law derived from judicial decisions rather than statutes. Related terms: Case Law, Precedent. In health care, common law influences malpractice standards.

Compensation Committee – A board sub-committee responsible for overseeing executive pay and incentive structures. Related terms: Corporate Governance, Say-on-Pay.

Compensation for Injuries (Workers' Compensation) – State-run programs providing benefits to employees injured on the job. Related terms: Employer Liability, Employer's Liability Insurance.

Compensation for Medical Malpractice – Monetary awards for damages resulting from professional negligence. Related terms: Tort, Damages.

Compensation Plan (Physician Incentives) – Structured remuneration models linking pay to quality metrics, productivity, or patient satisfaction. Related terms: Pay-for-Performance, Stark Law.

Compensable Injuries – Injuries that qualify for workers' compensation benefits. Related terms: Occupational Injury, Employer Liability.

Compliance Officer – An individual tasked with overseeing an organization's adherence to laws, regulations, and internal policies. Related terms: Compliance Program, Risk Management.

Compliance Program – A coordinated set of policies, procedures, and training designed to prevent, detect, and correct violations. Related terms: Audit, Corrective Action.

Compliance Risk – The potential for legal or regulatory sanctions, financial loss, or reputational damage due to non-compliance. Related terms: Risk Assessment, Internal Controls.

Comprehensive Care – An approach that integrates preventive, acute, and chronic services across settings. Related terms: Patient-Centered Medical Home (PCMH), Integrated Delivery System.

Concurrence – The legal principle that multiple parties may be held liable for a single injury. Related terms: Joint Liability, Vicarious Liability.

Constitutional Law (Health-Related) – Legal doctrines derived from the U.S. Constitution that affect health policy, such as the Commerce Clause and the Fourteenth Amendment. Related terms: Preemption, Individual Mandate.

Contraceptive Coverage (ACA) – The requirement that health plans cover FDA-approved contraceptives without cost-sharing. Related terms: Preventive Services, Essential Health Benefits.

Consumer Health Informatics – The study of how patients seek, understand, and use health information. Related terms: Health Literacy, Patient Portals.

Contractual Obligation – A duty imposed by a legally binding agreement. Related terms: Breach of Contract, Indemnification.

Contractual Penalty – A pre-determined sum payable for failure to meet contractual terms. Related terms: Liquidated Damages, Performance Bond.

Controlled Substance Act (CSA) – Federal law regulating the manufacture, distribution, and dispensing of drugs with abuse potential. Related terms: DEA Registration, Schedule I-V.

Coordinated Care – The deliberate organization of patient care activities among multiple providers to ensure seamless service delivery. Related terms: Care Transitions, Health Information Exchange (HIE).

Coordination of Benefits (COB) – A process that determines the order of payment when a patient has multiple insurance policies. Related terms: Primary Payer, Secondary Payer.

Corporate Practice of Medicine (CPOM) – A doctrine that restricts corporations from employing physicians to provide medical services. Related terms: Professional Corporation, Fee-Splitting.

Corporate Governance – The framework of rules, practices, and processes by which a health organization is directed and controlled. Related terms: Board of Directors, Compliance.

Cost-Benefit Analysis (CBA) – An economic evaluation method comparing the costs of an intervention to its benefits. Related terms: Health Economics, Return on Investment (ROI).

Cost-Sharing – Financial contributions required from patients, such as deductibles, co-payments, and co-insurance. Related terms: Benefit Design, Out-of-Pocket Maximum.

Covered Entity – Under HIPAA, a health plan, health care clearinghouse, or health care provider that transmits PHI electronically. Related terms: HIPAA, Business Associate.

Covered Services (ACA) – Health services that must be covered without cost-sharing under the Affordable Care Act. Related terms: Essential Health Benefits, Preventive Services.

CRNA (Certified Registered Nurse Anesthetist) – An advanced practice nurse authorized to administer

anesthesia. Related terms: Scope of Practice, State Nurse Practice Act.

CRS (Clinical Research Services) – Organizational units that manage the conduct of clinical trials. Related terms: IRB, GCP.

Cross-Border Telehealth – Delivery of health services across state or national lines via electronic communication. Related terms: Licensure Compacts, HIPAA.

CSA (Controlled Substances Act) – See Controlled Substance Act above.

CT (Computed Tomography) Scan Regulation – Federal and state guidelines governing radiation exposure and billing for CT imaging. Related terms: ALARA Principle, CMS Imaging Guidelines.

D

DAC (Data Access Committee) – A group that reviews requests for use of protected health data in research. Related terms: IRB, HIPAA Privacy Rule.

DAW (Dispense as Written) – A prescription directive that requires the pharmacist to dispense the exact brand or generic specified. Related terms: Formulary, Prior Authorization.

De-identification – The process of removing personal identifiers from data sets to protect privacy. Related terms: HIPAA Safe Harbor, Limited Data Set.

Defamation – A false statement that harms a person's reputation. In health care, defamation may arise from inaccurate public disclosures of a provider's performance. Related terms: Libel, Slander.

Deficiency Letter – A written notice from a regulator (e.G., CMS) identifying non-compliance issues. Related terms: Corrective Action Plan, Survey.

Deliberate Misrepresentation – Intentional false statements made to obtain reimbursement or other benefits. Related terms: Fraud, False Claims Act.

Denial Management – The systematic process of reviewing and appealing denied claims. Related terms: Revenue Cycle, Appeal Process.

Dependent – An individual who relies on a primary enrollee for health coverage, such as a child or spouse. Related terms: Beneficiary, Eligibility.

Department of Health and Human Services (HHS) – The federal agency that oversees health policy, including CMS, FDA, and CDC. Related terms: HIPAA, ACA.

Depreciation (Healthcare Assets) – Accounting method for allocating the cost of equipment over its useful life. Related terms: Capital Expenditure, Tax Depreciation.

Derivation Right – The right of a provider to retain a portion of a payer's savings resulting from efficiency improvements. Related terms: Shared Savings, Risk Contracts.

Designee – An individual authorized to act on behalf of a patient, such as a health care proxy. Related terms: Durable Power of Attorney, Advance Directive.

Detoxification (Legal Context) – The process of safely withdrawing a patient from substances under medical supervision, often subject to state licensing. Related terms: Substance Abuse Treatment, Regulatory Compliance.

Diagnostic Related Group (DRG) – A classification system that groups inpatient stays with similar clinical characteristics and resource use for payment purposes. Related terms: Prospective Payment System, Case Mix Index.

Digital Signature – An electronic method of signing documents that meets legal standards for authenticity. Related terms: e-Health Record, HIPAA Security Rule.

Direct Contracting – A CMS model where providers receive a fixed per-member per-month payment for delivering all services. Related terms: Value-Based Care, Risk Adjustment.

Disability Determination – The process by which Social Security evaluates eligibility for disability benefits. Related terms: SSA, Medical Evidence.

Disciplinary Action – Measures taken by licensing boards or employers in response to professional misconduct. Related terms: License Revocation, Professional Conduct.

Disclosure (HIPAA) – The act of releasing PHI to a third party. Must be authorized or fall under an exception. Related terms: Authorization, Minimum Necessary.

Discovery (Legal Process) – Pre-trial phase where parties exchange information and evidence. Related terms: Deposition, Subpoena.

Doctor of Osteopathic Medicine (DO) – A physician with training in osteopathic manipulative treatment. Related terms: Allopathic Medicine, Scope of Practice.

Drug Enforcement Administration (DEA) – Federal agency enforcing controlled substance laws. Related terms: CSA, Registration.

Drug Formulary – A list of medications covered by a health plan. Related terms: Prior Authorization, Tiered Pricing.

Dual Loyalty – Conflict where a provider's obligations to an employer conflict with patient interests. Related terms: Ethical Dilemma, Professional Responsibility.

Durable Power of Attorney for Healthcare (DPOA) – A legal document designating a person to make health decisions if the patient becomes incapacitated. Related terms: Advance Directive, Health Care Proxy.

E

E-Prescribing (Electronic Prescribing) – The electronic transmission of prescription information from prescriber to pharmacy. Related terms: HIPAA, e-Rx Standards.

E-Signature (Electronic Signature) – See Digital Signature above.

E-Verification – The process of electronically confirming a patient's insurance eligibility and benefits. Related terms: Real-Time Eligibility, Claim Submission.

EBITDA (Earnings Before Interest, Taxes, Depreciation, and Amortization) – A financial metric used to assess operational performance. Related terms: Financial Statement, Profitability.

EBT (Electronic Benefits Transfer) – A system that allows the electronic delivery of government benefits, sometimes used for Medicaid payments. Related terms: Medicaid, Payment Processing.

ECG (Electrocardiogram) Billing Compliance – Guidelines ensuring appropriate coding and documentation for cardiac monitoring services. Related terms: CPT, HCPCS.

ECG (Electrocardiogram) Interpretation Liability – Legal responsibility for accurate reading and reporting of ECG results. Related terms: Standard of Care, Malpractice.

ED (Emergency Department) Boarding – The practice of holding admitted patients in the ED due to lack of inpatient beds, raising legal concerns about timely care. Related terms: Patient Flow, CMS Conditions of Participation.

EEO (Equal Employment Opportunity) – Laws that prohibit workplace discrimination. Related terms: Title VII, ADA.

EEOC (Equal Employment Opportunity Commission) – Federal agency enforcing EEO laws. Related terms: Discrimination Claims, Harassment.

EHR (Electronic Health Record) – Digital version of a patient's chart that can be shared across providers. Related terms: Interoperability, HIPAA Security Rule.

EHR Incentive Program – CMS initiative offering financial incentives for meaningful use of certified EHR technology. Related terms: MU Stage, Promoting Interoperability.

EMR (Electronic Medical Record) – Digital version of a clinician's chart, often limited to a single practice. Related terms: EHR, Health IT.

EMTALA (Emergency Medical Treatment and Labor Act) – Federal law requiring hospitals to provide emergency care regardless of ability to pay. Related terms: Stabilization, Transfer Regulations.

Encroachment – In health law, the unauthorized practice of a professional's scope, such as a pharmacist providing medical diagnosis. Related terms: Scope of Practice, State Licensing.

End-Stage Renal Disease (ESRD) Medicare – A distinct Medicare entitlement for patients with ESRD, regardless of age. Related terms: Medicare Part A, Dialysis Coverage.

Enforcement Action – A regulatory response that may include fines, sanctions, or corrective measures. Related terms: Civil Money Penalty, Cease and Desist.

Entitlement Program – Government programs that provide benefits based on eligibility criteria, such as Medicare and Medicaid. Related terms: Public Insurance, Eligibility Determination.

Environmental Health Regulations – Rules governing sanitation, waste disposal, and infection control in health facilities. Related terms: OSHA, CDC Guidelines.

Equal Access Act – State statutes that require health insurers to cover services without discrimination. Related terms: Non-Discrimination, Benefit Design.

ERISA (Employee Retirement Income Security Act) – Federal law governing employer-sponsored health plans and benefits. Related terms: Pre-Existing Condition Exclusions, Plan Fiduciary.

ERISA Pre-Funding – The requirement that plan assets be sufficient to pay benefits. Related terms: Plan Funding, Fiduciary Duty.

Escrow Account (Healthcare) – An account used to hold funds for specific purposes, such as patient deposits or third-party reimbursements. Related terms: Trust Account, Compliance.

Essential Health Benefits (EHB) – A set of ten categories of services that ACA marketplace plans must cover. Related terms: ACA, Marketplace Plans.

Estoppel – A legal principle preventing a party from asserting a claim contrary to prior statements or actions. Related terms: Waiver, Representation.

Ex Parte Communication – Communication with a judge or arbitrator without the other party present, often prohibited in litigation. Related terms: Due Process, Procedural Fairness.

Exclusion List (CMS) – A list of individuals and entities barred from participating in Medicare and Medicaid. Related terms: Sanctions, False Claims Act.

Exhibit (Legal) – A document or item presented as evidence in a legal proceeding. Related terms: Deposition, Discovery.

F

FAFSA (Free Application for Federal Student Aid) – While primarily an education tool, health programs that offer tuition assistance may require FAFSA verification. Related terms: Financial Aid, Eligibility.

FARA (Foreign Agents Registration Act) – Requires individuals acting on behalf of foreign principals to register. Relevant for foreign-owned health organizations. Related terms: Transparency, Lobbying Disclosure.

FASB (Financial Accounting Standards Board) – Sets accounting standards, including those for health care entities. Related terms: GAAP, Financial Reporting.

Fee-for-Service (FFS) – Payment model where providers are reimbursed for each service rendered. Related terms: Utilization Management, Volume Incentive.

Fee-Splitting – The illegal practice of sharing fees for patient referrals. Related terms: AKS, Stark Law.

Fidelity Bond – Insurance protecting an organization from employee dishonesty. Related terms: Financial Controls, Risk Management.

Fiduciary Duty – The legal obligation to act in the best interest of another party. In health care, fiduciary duties arise in managed care contracts and patient-provider relationships. Related terms: Conflict of Interest, Duty of Care.

Filing Deadline (HIPAA) – The required time frame for submitting breach notifications to the HHS Office for Civil Rights. Related terms: Breach Notification Rule, Timely Reporting.

First-Party Payer – An entity that funds health care directly for its members, such as an employer or government program. Related terms: Self-Funding, Third-Party Payer.

First-Tier Provider – Primary care or other designated providers who serve as the initial point of contact. Related terms: Gatekeeper, Referral Management.

Fixed-Fee Contract – A payment arrangement where a set amount is paid for a defined scope of services. Related terms: Capitation, Risk Sharing.

FMLA (Family and Medical Leave Act) – Provides eligible employees up to 12 weeks of unpaid leave for certain family and medical reasons. Related terms: Leave of Absence, Job Protection.

FQHC (Federally Qualified Health Center) – Community health centers that receive federal funding and must meet certain service criteria. Related terms: Section 330, Sliding Fee Scale.

Fraud – Intentional deception to secure an unauthorized benefit. In health care, fraud includes billing for services not rendered. Related terms: False Claims Act, Kickback.

Fraudulent Claims Act (False Claims Act) – Federal law imposing liability on parties who submit false or fraudulent claims for government funds. Related terms: Qui Tam, Civil Penalties.

FTCA (Federal Tort Claims Act) – Allows private parties to sue the United States for certain torts committed by federal employees. Related terms: Sovereign Immunity, Medical Malpractice.

G

G-G Codes (HCPCS Level II) – Codes for medical supplies, equipment, and services not covered by CPT. Related terms: Billing, Reimbursement.

GAAP (Generally Accepted Accounting Principles) – Standard framework of guidelines for financial accounting. Related terms: FASB, Financial Statements.

Garnishment (Healthcare) – Court-ordered seizure of a portion of a patient's wages to satisfy a debt, sometimes applied to medical bills. Related terms: Debt Collection, Legal Process.

GCP (Good Clinical Practice) – International ethical and scientific quality standard for designing and conducting clinical trials. Related terms: IRB, FDA.

GME (Graduate Medical Education) – Training programs for physicians after medical school, funded partly by Medicare. Related terms: Residency, Fellowship.

Grace Period (Insurance) – Time after policy issuance during which the insurer may cancel for non-payment. Related terms: Renewal, Premium.

Grandfather Clause – Provision that allows existing arrangements to continue under old rules after new regulations are enacted. Related terms: Regulatory Transition, Compliance.