

MEDICAL BILLING VOCABULARY

ALLOWED AMOUNT

- The amount an insurance company will pay to reimburse a healthcare service or procedure. The patient will typically pay the balance if there is any remainder.

ANCILLARY SERVICES

- A service administered in a hospital or other inpatient facility beyond simple room and board. This includes physical therapy, consultations, diagnostic tests and other important medical procedures.

APPEAL

- The process by which a patient or provider attempts to **persuade an insurance payer to pay for more** (or, in certain cases, pay for any) of a medical claim. The appeal on a claim only occurs after a claim has either been denied or rejected (*See “Rejected Claim” and “Denied Claim”*).

APPLIED TO DEDUCTIBLE (ATD)

- The amount of money a patient owes a healthcare provider that goes to paying their annual deductible (*See “Deductible”*). A patient’s deductible varies, and depends on that patient’s insurance policy.

ASSIGNMENT OF BENEFITS (AOB)

- Insurance payments paid directly to the healthcare provider for medical services administered to the patient. The assignment of benefits occurs after a claim has been successfully processed.

AUTHORIZATION

- In certain cases, a patient's insurance plan requires them to **get permission from the payer before receiving a certain medical service**. If a patient ignores this authorization, the claim for that procedure **may be denied** and the patient will be saddled with the entire bill.

BENEFICIARY

- The person who receives benefits or insurance coverage. Beneficiaries are not always the ones paying for the plan, as in the case of children on their parent's healthcare plans.

CAPITATION

- An arrangement between a healthcare provider and an insurance payer that **pays the provider a fixed sum for every patient they take on**. Capitated arrangements typically occur within HMOs (*See “Health Maintenance Organization (HMO)”*). HMOs enlist patients to service providers, who are paid a certain amount based on the patient’s health risks, age, history, race, etc.

CLEAN CLAIM

- A claim received by an insurance payer that is **free from errors and processed in a timely manner**. Clean claims are a huge boon to providers, as they reduce turnaround time for the reimbursement process and lower the need for time-consuming appeals processes. Many providers send their claims to third parties, like clearinghouses (*See “Clearinghouse”*), that specialize in creating clean claims.

CLEARINGHOUSE

- A third-party organization in the billing process that is separate from the healthcare provider and the insurance payer. Clearinghouses **review, edit, and format claims** before sending them to insurance payers. This process is sometimes called “scrubbing.”

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

- A federal agency that **manages and oversees healthcare coverage** through Medicare and Medicaid. CMS, if you remember from Section 2, also maintains HCPCS codes. CMS directly affects the healthcare of over 100 million Americans, and this number is growing every day. *(See “Medicare” and “Medicaid”).*

CMS 1500

- A paper form used to submit medical claims to Medicare and Medicaid. Many commercial insurance payers also require providers to submit their claims using a CMS 1500, making this one of the most common and important tools in the medical billing process.

COBRA INSURANCE

- A federal program that grants a person recently terminated to retain health insurance with their former employer for 18 months, and up to three years if the former employee is disabled.

CO-INSURANCE

- A type of insurance arrangement between the payer and the patient that **divides the payment for medical services by percentage**. While this is sometimes used synonymously with a co-pay (*See: “Co-pay”*), the arrangements are different: while a co-pay is a fixed amount the patient owes, in a co-insurance, the patient owes a fixed percentage of the bill. These percentages are always listed with the payer’s percentage first (eg a 70-30 co-insurance).

COORDINATION OF BENEFITS

- When a patient is covered by more than one insurance company, those companies arrange themselves into a hierarchy. One payer becomes the primary carrier, and the remaining companies will assume the roles of secondary or tertiary carriers. These secondary or tertiary carriers may cover what costs are left over after the primary carrier reimburses the healthcare provider for the services rendered.

CO-PAY

- The amount a patient must pay to a provider before they receive any medical service. Co-pays are distinct from deductibles (*See “Deductible”*) and are slightly different from co-insurances. The co-pay for a patient may change depending on the patient’s plan and the medical service to be administered.

CROSSOVER CLAIM

- When a claim is sent from a primary insurance carrier to a secondary carrier, or vice versa, this is called a crossover claim.

DEDUCTIBLE

- The amount a patient must pay before an insurance company extends their coverage. This number, which you can think of as a threshold of payment, varies depending on a patient's insurance plan. A patient with a \$200 deductible, for example, would have to pay the first \$200 of a \$500 procedure, after which his insurance company would cover the rest. Note that this is distinct from a co-pay (*See “Co-pay”*), and that patients may often have to pay both their deductible and their co-pay before receiving a service.

ELECTRONIC CLAIM

- A **claim sent electronically** using a provider's billing software. Electronic billing is a rapidly expanding field, but you should note that claims must still adhere to billing regulations laid out by the federal government.

EXPLANATION OF BENEFITS (EOB)

- A document attached to a processed claim that explains to the provider and patient which services an insurance company will cover. EOBs may also explain what is wrong when a claim is denied.

ELECTRONIC REMITTANCE ADVICE (ERA)

- A digital version of the EOB, this document describes how much of a claim the insurance company will pay and, in the case of a denied claim, explains why the claim was returned.

FINANCIAL RESPONSIBILITY

- Financial responsibility describes which party—insurance payer or patient—**owes money to the healthcare provider**. Financial responsibility is outlined in the patient's healthcare insurance agreement.

FISCAL INTERMEDIARY (FI)

- A Medicare representative who processes Medicare claims.

GUARANTOR

- An individual paying for the insurance plan who is not also the patient. Parents are the most common examples of guarantors. You may also see guarantors referred to as “responsible parties.”

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- A law passed in 1996 that has lasting effects on the healthcare industry today. Title I of the act protects workers' health insurance when they change or lose jobs. Title II of the Act established standards and best practices in electronic health care. Refer to Courses 3-8 and 3-9.

HEALTH MAINTENANCE ORGANIZATION (HMO)

- A network of healthcare providers that offer coverage to patients for medical services exclusively within that network. We'll cover this type of insurance more thoroughly in Course 3-4.

INDEMNITY

- Also known as fee-for-service insurance, this type of insurance allows patients to receive care from any healthcare provider in exchange for higher fees and deductibles. Unlike an HMO, this plan allows for greater flexibility on the patient's part, but it does cost significantly more.

INDEPENDENT PRACTICE ASSOCIATION (IPA)

- A professional organization of **physicians or healthcare providers** who **have a contract with an HMO**. HMOs contract IPAs to provide services to patients within the HMO's network, but their individual practices do not have to be part of the HMO network.

MANAGED CARE PLAN

- A type of insurance plan wherein patients are only eligible to receive health care within the insurance company's network. HMOs and IPAS (See “*Health Maintenance Organization (HMO)*” and “*Independent Practice Association (IPA)*”) are examples of the managed care system.

MEDICARE

- A government insurance program, founded in 1965, that provides healthcare coverage for persons over 65 years old and for people with disabilities. Medicare provides coverage to more than 50 million people in the United States today, and is one of common places you'll send your medical claims to.

MEDICAID

- Medicaid provides insurance **coverage to low-income families and individuals**. It is essentially an insurance program for those who cannot afford full insurance coverage. Medicaid is funded at state and federal levels, but each state has its own version of Medicaid that must operate above the minimum requirements established by federal law.

NON-COVERED CHARGE (N/C)

- These are procedures or services on a claim that are not covered by a person's insurance plan.

PATIENT RESPONSIBILITY

- This is the amount a patient owes the healthcare provider after an insurance payer reimburses their portion of the claim. This may also be called the balance of the bill.

PRIMARY CARE PHYSICIAN (PCP)

- The physician that provides basic medical services for the patient, like general evaluation, and treatment for low-level injuries and non-serious illnesses. The PCP may also recommend other healthcare providers to the patient. In HMOs, many PCPs act as “gatekeepers,” assessing patients in the network and then sending them to the appropriate specialist in the HMO network.

POINT OF SERVICE (POS) PLAN

- In this insurance plan, a patient in an HMO network can go to a physician outside of their network if they are referred there and pay a higher deductible. Think of this as a cross between an HMO and basic indemnity insurance (*See “Health Maintenance Organization” and “Indemnity”*).

PREFERRED PROVIDER ORGANIZATION (PPO)

- A plan similar to an HMO, except that the insurance company, rather than the HMO itself, decides who is in the acceptable provider network. This is a common, subscription-based type of managed care.

PREMIUM

- This is the amount a patient regularly pays to an insurance company in order to receive coverage. Premiums are typically paid on a monthly or yearly basis.

PROVIDER

- Any healthcare facility that **administers healthcare to an individual**. Physicians, specialists, clinics, hospitals, general practitioners, and outpatient facilities are all considered providers.

SPECIALIST

- A **provider**, either an individual or an office, that **focuses on one type of healthcare**. Oncologists, physical therapists, and ophthalmologists are all examples of specialists. In many cases, a patient needs to be referred to a specialist by a primary care physician (*See “Primary Care Physician (PCP)”*) before seeing a specialist for the first time, especially if that patient is a member of a managed care network (*See “Managed Care”*).

SUBSCRIBER

- The person who is covered under a group policy. Members of managed care networks are subscribers to that network (See *“Managed Care”*).

SUPERBILL

- Used by healthcare providers, this is an itemized account of the provider's encounter with a patient. The superbill is the main source of data for creating the medical claim, and may include demographic information, insurance information, diagnoses and procedures performed.

SUPPLEMENTAL INSURANCE

- A **secondary or auxiliary insurance policy** that covers a patient's healthcare cost after they receive coverage from their primary insurer. Supplemental insurance may also be called secondary or, in the case of a patient having more than two policies, tertiary coverage. These supplemental insurance plans are often **put in place to help patients cover high deductibles or co-pays.**

TRIPLE OPTION PLAN (TOP)

- Sometimes called a “cafeteria plan,” this plan provides individuals who sign up the option of choosing between an HMO, PPO, or POS coverage (See “Health Maintenance Organization (HMO),” “Preferred Provider Organization (PPO),” and “Point of Service (POS) Plan”).

TRICARE

- Formerly known as CHAMPUS, this is a federal health insurance plan for active service members, retired service members, and their families.

UB04

- Similar in format to the CMS 1500 (See “CMS 1500”), this is another one of the most common claim forms.

UNTIMELY SUBMISSION

- Claims **must be filed within a certain timeframe.** Think of this as an expiration date. If a claim is not sent to an insurance company within the designated timeframe, this claim is labeled an untimely submission and will be denied.

UTILIZATION LIMIT

- Medicare places a **yearly limit on certain medical services**. If a patient passes this threshold, known as the utilization limit, they may be ineligible for Medicare coverage for that procedure.

WORKER'S COMPENSATION

- When a company pays for the health insurance of an employee who becomes injured or ill while performing their job's routine duties. Most states require companies to provide worker's compensation to their employees.