Glossary of Terms – Medical Billing

The following is a list of frequently used billing and insurance terms as defined by Centers for Medicare and Medicaid Services (CMS).

Advance Beneficiary Notice (ABN):
A notice that a provider or facility should give a plan beneficiary to sign in the following cases: Your doctor gives you a service that he or she believes that the plan may not consider medically necessary; and your doctor gives you a service that they believe the plan will not pay for. The ABN may also be referred to as a waiver.

Allowed Charge:
Contracted rate for individual charges determined by a carrier for a covered medical service or supply.

Appeal Process:
The process you use if you disagree with any decision about the health care process, service or payment. If the participant is in a managed care plan, they can file an appeal if the plan will not pay for, or does not allow or stops a service that the patient or provider believes should be covered or provided. The plan may have special protocols to follow in order to file an appeal. See the plan's membership materials or contact the plan for details about appeal rights and procedures.

Approved Amount:
The negotiated amount established in the agreement between the provider and plan to cover a particular service.

Assignment:
A process whereby a plan or payor, pays its share of the allowed charge directly to the physician or supplier.

Balance Bill:
Billing a member for the difference between the allowed charge and the actual charge.

Beneficiary:
The person who is eligible to receive benefits through a health insurance program.

Benefits:
The money or services provided and covered under an insurance policy.

Capitation:
A payment method for health care services. The physician, hospital, or other health care provider is paid acontracted ratefor each member assigned, referred to as "per-member-per-month" rate, regardless of the number or nature of servicesprovided. The contractual rates are usually adjusted for age, gender, illness, and regional differences.

Glossary of Terms (continued)

Carrier:
An entity that may underwrite or administer a range of health benefit programs. May refer to an insurer or a managed health plan.

Cash Basis:
The actual charge of the service when the service was performed.

Centers for Medicare and Medicaid Services (CMS):
The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Claim:
A claim is a request for payment for services and benefits received. Information is customarily submitted by a provider to establish that medical services were provided to a covered person.
CMS-1500: The uniform professional claim form.

Coinsurance:
The co-payment a member makes based on a percentage of the costs of the medical services received, usually around 10 to 20 percent. Coinsurance is usually found in indemnity, fee-for-service and PPO plans, often along with deductibles.

Confidentiality:
The ability to speak with the provider or representative without disclosing the information to an uninterested party.

Coordination of Benefits (COB):
A process that applies when determining which plan or insurance policy will pay first if multiple policies exist.

Copayment (co-pay):
The set amount, usually $5 to $25, an HMO member pays the provider for services. Unlike coinsurance, this amount is not based on a percentage of the actual cost of services, but is pre-determined.

Covered Services:
A health service or item that is included in the benefit plan and that is paid for either partially or fully.

Glossary of Terms (continued)

Covered Entity:
Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.

Deductible:
The dollar amount that a member must pay for medical services before health plan coverage begins.

Demographic Data:
Data that describe the characteristics of the beneficiary and/or guarantor. Demographic data include but are not limited to age, sex, race/ethnicity, and primary language.

Department of Health and Human Services (DHHS):
DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. It is the "parent" of CMS.

Determination:
A decision made to either pay in full, pay in part, or deny a claim.

Diagnosis Code:
ICD-9-CM diagnosis code sets that correspond to conditions that (co)existed at the time of treatment.

Disclosure:
Release or divulgence of information by an entity to persons or organizations outside of that entity.

Dis-enroll:
Ending health care coverage with a health plan.

Effective Date:
The date on which health plan coverage begins.

Eligibility:
Refers to the process whereby an individual is determined to be eligible for health care coverage through their plan.

Eligibility Date:
The date on which health plan coverage begins.

Enroll:
To join a health plan.

Glossary of Terms (continued)

Explanation of Benefits (EOB):
A coverage statement that is sent to the patient and/or provider when a claim is filed. The EOB shows what the provider billed for, the plan's approved amount and how much they paid.

Fee Schedule:
A list of services and their respective charge

Fee-for-Services:
A method of paying the provider for service or treatment based on the fee schedule.

Guarantor:
The person responsible for payment of rendered services. The guarantor is customarily the person bringing the patient in for treatment. This person is not necessarily the same as the subscriber.

Health Care Provider:
A person who is trained and licensed to give health care.

Health Insurance Portability and Accountability Act (HIPAA):
HIPAA is the Health Insurance Portability and Accountability Act signed into law in 1996. An Administrative Simplification section in the law requires adoption of standards for security, privacy and electronic healthcare transactions.

Health Maintenance Organization (HMO):
A legal corporation that provides health care in return for pre-set monthly payments. For most HMOs, members must use the physicians, hospitals and other health care professionals in the HMO's network in order to be covered for their care. There are several models of HMO, including the Staff Model, Group Model, IPA Model, Direct Contract Model and Mixed Model.

Health Plan:
An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or HMO.

Indemnity:
This is a form of coverage offered by most traditional insurers.

Managed Care:
An HMO, PPOs and some forms of indemnity insurance coverage that incorporate preadmission certification and other utilization controls.

Glossary of Terms (continued)

Managed Care Organization (MCO):
A health plan that provides coordinated health care through a network of primary care physicians and hospitals for pre-set monthly payments.

Medicaid:
Medical Assistance is a joint federal and state program to cover medical costs for qualifying low-income individual. Medicaid programs vary from state to state.

Medicaid MCO: A Medicaid MCO provides comprehensive services to Medicaid beneficiaries. Maryland has seven (7) MCO's, Amerigroup, Maryland Physicians Care, Priority Partners, Riverside Health, United Health Care Community Plan, MedStar, and Jai.

Medically Necessary:
Services or supplies that: are proper and needed for the diagnosis, or treatment of your medical condition; are provided for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of the patient or provider.

Medigap Policy:
A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage.

Member:
An eligible employee or eligible retiree who, through his or her place of employment, has enrolled in a health plan.

Network:
A group of health care providers and suppliers of other goods and services to provide service to patients.

Non-covered Service:
The service (a) does not meet the requirements of a benefit and (b) may not be considered reasonable and necessary.

Non-participating Physician:
A provider that is not contracted or accepts assignment with a particular plan.

Nurse Practitioner:
A nurse who has advanced training and assists physicians by providing care to patients in their absence. NPs are considered providers.

Glossary of Terms (continued)

Out of Network:
Services a member receives from a health care provider who does not belong to the member's health plan's network of selected and approved physicians and hospitals.

Out of Pocket Costs:
Health care expenses that the patient is responsible for as they are not fully or partially covered by their plan.

Participating Physician or Supplier:
A provider who agrees to accept assignment on the claims. These providers should only initially bill for the patient's cost share amount.

Payer: Insurance company.

PCP - Primary Care Physician (PCP):
A physician, who usually specializes in family practice, general practice, internal medicine or pediatrics, who provides or coordinates patient care.

PMS (Practice Management System):
The software or system the provider uses for billing.

Point of Service (POS):
A health plan option that allows members to use either a network provider or a non-network provider at their discretion. If a member chooses to go out of network, they may pay a higher co-pay or deductible.

Preferred physicians and/or health care practitioners (providers):
The term used to describe the physicians, health care practitioners and facilities included in an insurance plan network.

Preferred Provider Organization (PPO):
A network of doctors and hospitals that provide health care services at a pre-negotiated lower price. Members receive better benefits when they use network providers, but have the option to used out-of-network providers for higher out-of-pocket costs.

Premium:
The predetermined monthly membership fee a subscriber or employer pays for health plan coverage.

Preventive Care:
Care designated to keep the patient healthy or to prevent illness, such as colorectal cancer screening, yearly mammograms, and flu shots.

Glossary of Terms (continued)

Primary Care:
A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic level of health care.

Primary Payer:
An insurance policy, plan, or program that pays first on a claim for medical care.

Protected Health Information (PHI):
Individually identifiable health information transmitted or maintained in any form or medium, which is held by a covered entity or its business associate. Identifies the individual or offers a reasonable basis for identification. Is created or received by a covered entity or an employer. Relates to a past, present, or future physical or mental condition, provision of health care or payment for health care.

Provider: Any healthcare provider such as hospital, physician, non-physician provider, laboratory, etc. that provides medical services.

Referral:
The formal process that gives a health plan member authorization to receive care from a provider other than his or her primary care provider. Without a referral, such care may not be covered.

Secondary Payer:
An insurance policy that supplements the primary coverage and pays second on a claim for medical care.

Self-Insurance:
Practice of an individual, group of individuals, employer or organization that assumes complete responsibility for losses, which might be insured against, such as health care expenses. In effect, "self-insured" groups have no real insurance against potential losses and instead maintain a fund out of which is paid the contingent liability subject to self-insurance.

Self-Pay:
A term to mean that the patient owes the medical bill.

Statement:
A bill that is sent to the patient for services/items provided.

Subscriber:
An eligible employee or eligible retiree who, through his or her place of employment, has enrolled in a health plan.

Glossary of Terms (continued)

Super-Bill (also referred to as; charge document, fee slip; routing slip; encounter form):
An internal document created and used to capture medical charges. The superbill typically contains the most frequently used CPT and ICD codes, patient demographic and insurance information.

Termination Date:
The date that an agreement expires; or, the date that a subscriber and/or member ceases to be eligible.

Third Party Administrator (TPA):
An organization that administers health care benefits-including claims review, claims processing, etc.-usually for self-insured employers.

Timely Filing:
Period of time that the provider has to file a claim. This may vary by insurance carrier. Typically the filing period is 6 to 12 months.

Transaction: The exchange of information between two parties to carry out financial or administrative activity.