MEDfx PM
Glossary of Medical Billing Terms

Adjudication The determination of a member's payment or financial responsibility after a claim is applied to a member's benefits.

Allowable amounts maximum reimbursement the member's health insurance allows for a specific service.

Assignment of Benefits The payment of health insurance benefits to a healthcare provider rather than directly to the member of a health insurance plan.

Batch Claims To generate a group of claims in a batch for transmitting or printing.

Billing Provider A provider who bills for a service he or she has rendered, or for a service another provider has rendered. The billing provider may or may not be the rendering provider. For example, a physician may be the billing provider; a nurse practitioner may be the rendering provider.

Capitation A payment method in which the provider is paid a set amount per member, per month. The provider receives the same amount regardless of how many times a patient uses a provider's services.

Carrier Any insurer, managed-care organization, or group hospital plan

CLIA See Clinical Laboratory Improvement Amendments.

Clinical Laboratory Improvement Amendments (CLIA) A set of standards for laboratory testing that ensures the accuracy, reliability and timeliness of patient test results. CLIA requires all facilities that perform tests on materials derived from the human body for the purpose of diagnosing, prevention or treatment of any disease to meet certain Federal requirements. CLIA-waived tests are categorized as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result."

Centers for Medicare and Medicaid Services (CMS) part of the federal government's Department of Health and Human Services, CMS administrates the government's Medicare and Medicaid programs. The CMS establishes standards to which healthcare providers must comply to meet certain certification requirements.

CMS-1500 02/12 Effective 04/01/14, the CMS-approved paper claim form that accommodates ICD-10 and eight diagnoses, as well as supervising and ordering providers.

COB See Coordination of Benefits.

Coinsurance The amount a patient or guarantor is obliged to pay for covered medical services once the patient has satisfied a co-payment or deductible required by the health insurance plan.

Contractual Adjustment The difference between the amount billed and the amount allowed for a procedure code.

Coordination of Benefits (COB) A process in which the insurance company determines whether it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy.

Copay A fixed payment amount defined by the payer that the patient is responsible for each time a service is rendered. Co-payments are due at the time of visit.

Courtesy Claim a claim with $0.00 balance due, submitted to payer for patient reimbursement.

Crossover coverage Coverage in which a primary payer electronically forwards payment information to the secondary payer. (In these cases, a secondary claim is not generated.)

Current Procedural Terminology (CPT) Procedure (px) codes. A coding system used to describe treatments or services. These codes, developed and maintained by the American Medical Association, are updated annually.

Deductible A specific dollar amount a health insurance company may require patients to pay, out-of-pocket, each year, before the health insurance plan begins to make payments for claims.

DME See Durable Medical Equipment.

Durable Medical Equipment (DME) Medical equipment used in the course of treatment or home care.

EDI See Electronic Data Interchange.

EDI Clearinghouse a central agency for the collection, edit and distribution of claims to payers.

Electronic Data Interchange In healthcare, the standardized, electronic transmission of health information and health-insurance information.

Electronic Remittance Advice (ERA) An electronic version of the EOB in ANSI-835 standard file.

Eligibility Determination of patient's enrollment and financial responsibility to a payer.

Encounter Form/Superbill/Routing Slip A charge slip showing, at a minimum, the patient name, provider, date of service, procedure(s) performed and diagnosis.

EOB See Explanation of Benefits.

ERA See Electronic Remittance Advice.

Explanation of Benefits (EOB) A statement from the insurance company showing what was billed; the allowed amount approved by insurance; the amount paid; and the amount of patient responsibility.

Fee for Service (FFS) Billing in which providers charge a fee for each service provided.

FFS See Fee for Service.

Group Insurance Insurance for individuals who are covered under a single health insurance contract; usually a group of employees.

Group Practice A practice registered as a group entity with one tax ID. The practice is assigned a group NPI in addition to an individual NPI.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Legislation mandating specific privacy rules and practices for medical care providers and health insurance companies.

Health Maintenance Organization (HMO) A network of providers that contract exclusively with the HMO, or who agree to provide services to members at a pre-negotiated rate.

Health Services Account (HSA) A tax-advantaged savings account to be used in conjunction with certain high-deductible (low-premium) health insurance plans to pay for qualifying medical expenses.

HMO See Health Maintenance Organization.

Hospice Inpatient or home care for a terminally ill patient.

HSA See Health Services Account.

ICD-9/ICD-10 The International Classification of Diseases (ICD)'s Diagnosis (dx) codes.

Indemnity Plan A fee-for-service plan allowing patients to direct their own health care.

Individual Practice Association (IPA) An organization of physicians who may maintain separate offices or practices, but negotiate contracts as a group with insurance companies and medical facilities.

Inpatient A patient admitted to a hospital.

Interest Earned Additional money that a payer pays a provider because a claim was not settled in a predetermined length of time.

IPA See Individual Practice Association.

Managed Care a variety of healthcare and health-insurance systems that attempt to guide a member's use of benefits, typically by requiring that a member coordinate his or her healthcare through a primary care physician, or by encouraging the use of a specific network of healthcare providers.

Medicare Supplement Provided to an individual or group, health insurance that is intended to help fill gaps in Medicare coverage. (Supplement insurances may cross over from the primary insurance and are never considered primary).

Modifiers A two-digit code, included with procedure code, which is used to alter the procedure code. Procedure codes may be modified to more accurately represent the service or item rendered. Modifiers are used to add information or change the description of service in order to improve accuracy or specificity.

National Drug Code (NDC) A unique numeric identifier assigned to each medication by the Food and Drug Administration.

Network Provider A healthcare provider that has a contractual relationship with a health insurance company.

National Provider Identifier (NPI) A unique identifier assigned to covered healthcare providers, facilities and organizations.

NDC See National Drug Code.

NPI See National Provider Identifier.

Out of Network Healthcare rendered to a patient outside of the health insurance company's network of preferred providers.

Outpatient A patient who receives care at a medical facility but is not admitted overnight.

Participating Provider A provider who agrees to accept assignment of services provided.

Patient Statements A bill showing a patient's remaining financial responsibility.

Payer Fee Schedule A payer's allowed amounts for procedures.

Payer ID a unique number assigned to all payers that accept claims electronically.

PCP See Primary Care Physician.

Place of Service (POS) A standard code that must be included on professional claims to specify where services were rendered.

POS See Place of Service.

PPO See Preferred Provider Organization.

Preferred Provider Organization (PPO) A group of preferred healthcare providers for whom claims are paid at the highest level.

Primary Care Physician (PCP) A patient's main healthcare provider.

Primary Insurance The first insurance responsible for adjudication when a patient has more than one insurance.

Prior Authorization A payer's pre-approval of a provider to perform a procedure.

Private Practice A practice not credentialed as a group.

Recall The process of contacting a patient to return at a later date. It is used instead of scheduling an appointment.

Referral A primary care physician's authorization to see a specialist for diagnosis or treatment.

Referring Provider A provider who directed a patient to another provider.

Refund A return of money to a payer due to overpayment.

Release of Medical Records A patient's signature that allows release of medical records from the provider to the payer for adjudication of a claim.

Rendering Provider The person who provided services to or treated the patient.

Responsible Party The person or entity responsible for the patient balance, and the person to whom the statement is addressed.

Risk Withheld A portion of expected payment that is withheld until the end of a period; it is used as an incentive for efficient care.

Secondary Insurance The second insurance responsible for adjudication.

Subscriber The name of the insurance-policy holder.

Supervising Provider A provider giving direction or supervision to another provider.

Take-back Money previously paid on a claim that is retracted by a payer.

Taxonomy Number A code set to categorize type and/or specialization of health care providers.

Tertiary Insurance A third insurance, after primary and secondary insurance, responsible for adjudication.

Timely Filing A defined length of time a payer allows for filing claims after a service date.

Type of Service (TOS) A standard code set describing procedure codes.

UB-04 An institutional claim-filing form, normally used by inpatient facilities and Federally Qualified Community Health Centers (FQCHCs) to submit charges for reimbursement.

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