

Glossary of Billing Terms

Ambulatory Patient Classifications (APC) - A system for classifying outpatient services and procedures for purposes of payment. Call the Centers for Medicare and Medicaid Services at 1-800-633-4227 and request a free brochure.

Assignment - A process under which Medicare pays its share of the allowed charge directly to the physician or supplier. Medicare will do this only if the physician accepts Medicare's allowed charge as payment in full.

Beneficiary - Someone who is eligible for or receiving benefits under an insurance policy or plan.

Beneficiary Liability - The amount beneficiaries must pay for covered services. These include co-payments, coinsurance, deductibles, and balance billing amounts.

Certificate of Coverage (COC) - A description of the benefits included in a carrier's plan. The certificate of coverage is required by state laws and represents the coverage provided under the contract issued to the employer.

Charity Care - Free or reduced-fee care provided due to financial situation of patient.

Children's Health Insurance Program (CHIP) - A federal program jointly funded by states and the federal government, which provides medical insurance coverage for children not covered by state Medicaid-funded programs.

Coding - How physicians' services are identified and defined.

Co-insurance - A type of cost sharing where the beneficiary and insurance provider share payment of the approved charge for covered services in a specified ratio after payment of the deductible by the insured. For example, for Medicare physicians' services, the beneficiary pays co-insurance of 20 percent of allowed charges.

Consolidated Omnibus Budget Reconciliation Act (COBRA) - A federal law that requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance coverage has been terminated. Applies to employers with 20 or more eligible employees. Typically, COBRA makes continued coverage available for up to 18 or 36 months. COBRA enrollees may be required to pay 100 percent of the premium, plus an additional 2 percent.

Coordinated Coverage - Integrating benefits payable under more than one health insurance (for example, Medicare and retiree health benefits). Coordinated coverage is typically arranged so the insured benefits from all sources not exceeding 100 percent of allowable medical expenses. Coordinated coverage may require beneficiaries to pay some deductible or co-insurance.

Coordination of Benefits (COB) - A provision that applies when a person is covered under more than one group medical program. (See "Coordinated Coverage.")

Co-payment - 1) A fixed dollar amount paid for a covered service by a beneficiary. (See "Co-insurance" and "Deductible.") 2) Amount that a member of a health plan has to pay for specific health services, such as visits to a physician. (See "Beneficiary Liability" and Co-insurance.")

Date of Service (DOS) - The date(s) health care services were provided to the beneficiary.

Deductible - 1) The amount the patient pays for medical care before insurance covers the balance. 2) A type of cost sharing where the beneficiary pays a specified amount of approved charges for covered medical services before the insurer will pay for all or part of the remaining covered services. 3) Total amount a member of a health plan has to pay for services before that person's plan begins to cover the costs of care. (See "Beneficiary Liability.")

Diagnosis-Related Groups (DRGs) - 1) A system of classifying patients on the basis of diagnosis for purposes of payment to hospitals. The DRG system classifies payments into groups based on the principal diagnosis, type of surgical procedure, presences or absence of complications, and other relevant indicators.

Duplicate Coverage Inquiry (DCI) - A request to an insurance company or group medical plan by another

insurance company or medical plan to find out whether other coverage exists. (See "Coordinated Coverage.")

Durable Medical Equipment (DME) - Medical equipment which: can withstand repeated use; is not disposable; is used to serve a medical purpose; is generally not useful to a person in the absence of sickness or injury, and is appropriate for use in the home. Examples include hospital beds, wheelchairs, and oxygen equipment.

Employee Retirement Income Security Act of 1974 (ERISA) - This law mandates reporting, disclosure of grievances and appeals requirements, and financial standards for group life and health. Self-insured plans are regulated by this law.

Enrollee - Person who is covered by health insurance.

Explanation of Benefits (EOB) - The coverage statement sent to covered persons listing services rendered, amount billed, and payment made. This normally would include any amounts due from the patient, as described in "Beneficiary Liability," "Co-insurance," "Deductible," and "Co-payment."

Health Care Provider - An individual or institution that provides medical services; e.g., physician, hospital, or laboratory. This term should not be confused with an insurance company that "provides" insurance.

Health Insurance - Coverage that provides for the payment of benefits as a result of sickness or injury. Includes insurance for losses from accident, medical expense, disability, accidental death, or dismemberment.

Health Insurance Portability and Accountability Act (HIPAA) - A federal law intended to improve the availability and continuity of health insurance coverage that, among other things:

- places limits on exclusions for pre-existing medical conditions;
- permits certain individuals to enroll for available group healthcare coverage when they lose other health coverage or have a new dependent;
- prohibits discrimination in group enrollment based on health status;
- guarantees the availability of health coverage to small employers and the renewability of health insurance coverage in the small and large group markets; and
- requires availability of non-group coverage for certain individuals whose group coverage is terminated.

Health Maintenance Organization (HMO) - An entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium.

Home Health Agency (HHA) - A facility or program licensed, certified, or otherwise authorized according to state and federal laws to provide health care services in the home.

Hospital Inpatient Prospective Payment System (PPS) - Medicare's method of paying acute care hospitals for inpatient care. Prospective per-case payment rates are set at a level intended to cover operating costs for treating a typical inpatient in a given DRG.

International Classification of Diseases, 9th Edition (Clinical Modification) (ICD-9-CM) - A listing of diagnosis and identifying codes used by physicians and hospitals for reporting diagnoses and procedures of health plan enrollees.

Medicaid - 1) A state/federal benefit program for the poor who are aged, blind, disabled, or members of families with dependent children. Each state sets its own eligibility standards. Only 40 percent of individuals with income below the poverty level currently are covered.

Medicare - A federal health benefit program for people over 65 and disabled and disabled that covers 35 million Americans - or about 14 percent of the population - for an annual cost of over \$120 billion. Medicare pays for 25 percent of all hospital care and 23 percent of all physician services.

Medicare Assignment - See "Assignment."

Medicare + Choice - A program created by the Balanced Budget Act of 1997. Beneficiaries will have the choice during an open season each year to enroll in a Medicare + Choice plan or to remain in traditional Medicare. Medicare + Choice plans may include coordinated care plans (HMOs, PPOs, or plans offered by provider-

sponsored organizations); private fee-for-service plans, or plans with medical savings accounts.

Medicare Supplement Policy (Medsupp) - The insurer will pay a policyholder's Medicare co-insurance, deductible, and co-payments for Medicare Part A and B and may provide additional supplement benefits according to the supplement policy selected. Also called Medigap of Medicare wrap.

Medigap Insurance - Privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles, co-insurance and balance bills, as well as payment for services not covered by Medicare.

Medigap Plan - Purchased by Medicare enrollees to cover co-payments, deductibles, and health care goods or services not paid for by Medicare. Also known as a Medicare supplement policy.

Medigap Policy - A privately purchased insurance policy that supplements Medicare coverage.

Non-Participating Provider (Non-par) - Also known as out-of-network provider. A healthcare provider who has not contracted with the carrier of a health plan to be a participating provider of health care.

Out of Network (OON) - Coverage for treatment obtained from a non-participating provider. Typically, it requires payment of a deductible and higher co-payments and co-insurance than for treatment from a participating provider.

Out-of-Pocket-Costs/Expenses (OOPs) - The portion of payments for covered health services required to be paid by the patient, including co-payments, co-insurance, and deductible. (See "Beneficiary Liability," "Co-insurance," "Deductible," and "Co-payment.")

Over-the-Counter Drug (OTC) - A drug product that does not require a prescription under federal or state law.

Pre-Admission Certification (PAC) - A review of the need for inpatient hospital care, done before the actual admission.

Part A Medicare - Medical Hospital Insurance (HI) under Part A of Title XVIII of Social Security Act, which covers patients for inpatient hospital, home health, hospice, and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and co-payments.

Part B Medicare - Medicare Supplement Medical Insurance (SMI) under Part B of Title XVII of the Social Security Act, which covers Medicare beneficiaries for physician services, medical supplies, and other outpatient treatment. Beneficiaries are responsible for monthly premiums, co-payments, deductibles, and balance billing.

Point-of-Service Plan (POS) - A health benefit plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers.

Pre-existing Condition (PEC) - Any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage. Pre-existing conditions may not be covered for some specified amount of time as defined in the certificate of coverage (usually six to 12 months). Individuals can be required to satisfy a pre-existing waiting period only once, so long as they maintain continuous group health plan coverage with one or more carriers.

Pre-existing Condition Exclusion - A practice of some health insurers to deny coverage to individuals for a certain period for health conditions that already exist when coverage is initiated.

Preferred Provider Organization (PPO) - A program that establishes contracts with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits and lower member costs for services received from preferred providers, thus encouraging covered persons to use these providers.

Premium - 1) Amount paid periodically to purchase health insurance benefits. 2) The amount paid or payable in advance, often in monthly installments, for an insurance policy.

Prevailing Charge - What determines a physician's payment for a service under the Medicare payment system.

Primary Care Network (PCN) - A group of primary care physicians who have joined together to share the risk of providing care to their patients who are covered by a given health plan.

Primary Care Physician (PCP) - A physician, the majority of whose practice is devoted to internal medicine, family/general, and pediatrics. An obstetrician/gynecologist sometimes is considered a primary care physician, depending on coverage.

Reasonable and Customary (R&C) - A term used to refer to the commonly charged or prevailing fees for health services within a geographic area.

Secondary Insurance - Any insurance that supplements Medicare coverage. The three main sources for secondary insurance are employers, privately purchased Medigap plans, and Medicaid.

Skilled Nursing Facility (SNF) - A facility, either freestanding or part of a hospital, that accepts patients seeking rehabilitation and medical care that is less intense than that received in a hospital.

Sub-Acute Care - Usually described as a comprehensive inpatient program for those who have experienced a serious illness, injury, or disease, but who do not require intensive hospital services. The range of services considered sub-acute can include infusion therapy, respiratory care, cardiac services, wound care, rehabilitation services, post-operative recovery programs for knee and hip replacements, cancer, stroke, and AIDS care.

Third Party Administrator (TPA) - An independent person or corporate entity (third party) that administers group benefits, claims, and administration for a self-insured company or group.

Usual, Customary, and Reasonable (UCR) - A term used to refer to the commonly charged or prevailing fees for health services within a geographic area.

Utilization Review (UR) - A formal assessment of the medical necessity, efficiency and/or appropriateness of health care services and treatment plans on a prospective, concurrent, or retrospective basis.