Medical Billing Terminology

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This handout provides an overview billing terminology associated with third-party billing. The information is for educational and informational purposes only. Please keep in mind that there are hundreds of insurance companies and they will each have their own guidelines for reimbursement. Care has been taken to confirm the accuracy of this information. However, I cannot accept any responsibility for errors or omissions or for consequences from the application of the information supplied in the following pages and make no warranty, express or implied, with respect to its contents. To copy or reprint, please call me for permission at 781-343-1505.
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General Terminology

Abandoned property:

Any financial asset with no activity by its owner for an extended period of time. This includes savings accounts, checking accounts, unpaid wages or commissions, stocks, underlying shares, un-cashed dividends, customer deposits or overpayments, certificates of deposit, credit balances, refunds, money orders, paid-up life insurance policies, safe deposit boxes, and un-cashed benefit checks, gift certificates, etc. Abandoned Property does not pertain to land, houses or real estate of any kind.

In accordance with the Massachusetts Abandoned Property Act, Chapter 200A of M.G.L., property becomes "abandoned" when the owner cannot be contacted for a three-year period by the holder of the asset, or for fifteen years in the case of traveler's checks.

The Massachusetts Abandoned Property Law (M.G.L.c. 200A), requires business entities and others to review their records each year to determine whether they are in the possession of any abandoned funds, securities or other property which is reportable under Chapter 200A and to make an annual report of their findings.

For more information, visit **www.mass.gov** and select abandoned property.

Accept assignment

The provider of the service agrees to accept payment from the carrier and collect from the patient only up to the amount approved by the carrier. For example:
Fee: $125
Insurance allows: $100
Patient has 80% coverage, therefore, insurance company pays $80.
Provider can bill the patient for $20 and must adjust (write-off) $25.

Accounts receivable

A grouping of accounts listing money owed to the business or practice due from patients, clients and third-party payers. The money owed is "aged" by dates such as 30 days, 60 days, 120 days, etc. known as "Aged AR".

Adjudication	This is the final decision in claim settlement.
Adjustment	Remember that the charged fee is always the same for all patients. A contractual adjustment/write-off is the difference between the fee the provider charged for medical services and the insurance carrier's allowed fee for those services. Another example of a write-off is a bad debt—e.g. the client did not pay or the office did not follow the insurance company's guidelines, therefore, no payment is given by the insurance company. An example of an adjustment is professional courtesy (one doctor treats another doctor or the doctor's family).
(EIN) Employer Tax Identification Number	A tax number assigned by the IRS to identify deposits covering the payroll taxes withheld from employee earnings. This number is often used when completing insurance forms.
Allowed charge	The amount that the insurance company sets for a covered service.
Assignment of benefits	An agreement signed by the insured giving permission for the benefits (payments) to be issued to the provider of services.
Attending physician	The physician who is treating the patient or is responsible for the patient's care.
Authorization to release information	Signed permission by the patient authorizing the doctor to release privileged information.
Authorization	Certain services such as inpatient admission and certain outpatient services are reviewed by the insurance company to see if the services are medically necessary for the patient. The approval is known as "Authorization".
Balance billing	Billing the patient for the difference between the physician's fee and the insurance company's allowed fee.
Benchmarking	Benchmarking is the measuring and comparing of data and performance levels of your practice/business to those businesses that are classified as the "best or superior".

Billing balance	It is the amount between the amount allowed by the insurance company and the provider's charge. When a provider agrees to accept assignment, the provider cannot balance bill above the allowed charge. (Also known as balance billing)
Birthday rule	When determining primary and secondary payer, some companies use the birthday rule. When a patient (usually a child) is covered by two plans, the insurance that is billed first is determined by the parent that has the first birthday (day and month) of the year.
Carrier	An insurance company that underwrites the insurance coverage.
C.H. E. D. D. A	A charting procedure that uses the following guideline. **C** stands for chief complaint, **H** is history of the present illness, **E** for examination, **D** for details of the list of complaints and problems, **D** for drugs and diagnosis, **A** for assessment, and **R** for return visit or referral information
Claim form	The form that is sent to the insurance company for processing.
Claimant	The individual making the request to receive payment for services.
Clean claim	A claim form properly completed and containing all the data necessary for immediate processing by the insurance carrier.
CMS	Previously called HCFA (pronounced hickfa). In July 2001, the Health Care Financing Administration became the Centers for Medicare and Medicaid Services (CMS). The Centers for Medicare & Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA , and CLIA.
CMS-1500	The standard Medicare claim form. Most HMO's and PPO's will accept a claim on this form. For physicians, Massachusetts Medicaid does not use the 1500 form. For additional information, visit www.cms.hhs.gov/forms.

Term	Definition
Collection formulas	Calculations that measure the financial status of the practice. See *Benchmarking and Measuring Financial Data* article in appendix.
Collection agency	A company that specializes in collecting bad debt.
Compliance program	Federal guidelines to help prevent the submission of erroneous claims or engaging in unlawful conduct involving the Federal health care programs. The OIG (Office of Inspector General) has prepared guidelines for individual and small group physician practices, which can be found in the Federal Register, Vol. 65, No. 194.
Consultation	A consultation request occurs when one doctor asks another doctor to see his/her patient. The patient is often seen in the hospital or nursing home (although can be seen in the office). A consult is one visit. A "specialist" usually gives the consult. For example, a primary care physician may request a consultation from a cardiologist, endocrinologist, etc. When billing for a consultation, a referring doctor is always required for claim submission. Note: Consults are one visit. The doctor may, however, suggest that the patient also be seen at his/her office. When that occurs, the additional visits become office visits.
Coordination of benefits (COB)	When a patient is covered by more than one insurance carrier, the primary carrier takes into consideration the responsibility of the other carrier. The insurance companies "coordinate" payment to prevent "over payment."
CPT	(Physician's Current Procedural Terminology) is a medical coding system maintained and published by the American Medical Association. A procedure is given a number. The codes are five digits. In some cases a modifier may be used. A modifier is a two-digit code added after the CPT number. It indicates that a procedure has been altered or modified in some way--reduced or increased.
Credit and Collection Laws	Include the following: Federal Collection and Collection Laws, Electronic Fund Transfer Act, Truth in Lending Act, Truth in Lending Consumer Credit Cost Disclosure, and Fair Debt Collection Practices Act. Note: When checking laws, make certain to check both Federal and state laws.

Credits	Balances on a patient's account that should be refunded to the patient. See abandoned property.
Day sheet	The chronological summary of all the practice's financial transactions posted daily to the individual patient ledger cards.
Deductible	The amount of money the patient must pay in a given time before the insurance company will pay for benefits. The deductible is usually a set amount or percentage determined by the patient's insurance agreement. Deductibles vary. Usually the higher the deductible, the less the insurance plan costs.
Diagnosis	A diagnosis is what the doctor thinks is wrong with a patient.
DRG	A classification system that groups patient who are medically related, such as diagnosis, treatment, and length of hospital stay. Medicare Part A (hospital insurance) pays a fixed dollar amount for principal diagnosis listed in the DRG.
Employer self-insured programs	An insurance program whereby employers have sufficient capital to insure their own employees for medical care without contracting with a commercial carrier for coverage.
Evaluation and Management (E/M)	A classification in CPT coding that describes categories such as office visits, hospital visits, and consultations. Most visits are divided into two or more subcategories of E/M services, such as the location, patient status, and level of service.
Explanation of benefits (EOB) or remittance advice	An explanation of how the claim is settled. The EOB is sent at the time of reimbursement or rejection of a claim.
Fee-for-service	The method of billing whereby the provider bills for each visit or service rendered rather than an all-inclusive or prepaid fee basis.
Gender rule	When determining primary and secondary payer, some companies use the gender rule. When a child is covered by both parent's insurance, the father's insurance is billed first.

Global fee	The fee for total care of a surgical case including all pre/post-operative care. For example: pregnancy care & delivery and surgery.
HCPCS	(pronounced hick-picks) The HCFA Common Procedural Coding System used for reporting outpatient health care services provided to Medicare beneficiaries. It is a supplement to the CPT coding system. It lists supplies, services and some physician/dental services not listed in the CPT book.
Hospital discharge summary	This summary is completed by the physician and hospital at the time of the patient's release from the hospital.
Hospital operative report	This report is a detail of the operative procedure and finding. At times, the insurance company may request a copy of this report.
ICD-9-CM	(The International Classification of Diseases 9th Revision Clinical Modification) ICD-9-CM is the standard coding system for diagnostic classification for both governmental and private insurance coding. It is published in a three volume set. The 10th edition is pending implementation. See http://www.icd9coding/flashcode/home.jsp
In-patient care	The day to day care given by a doctor to a patient in the hospital.
Indemnity plan	This type of plan gives the member the freedom to receive services from any participating provider. The member does not have to stay within a specific network of providers in order to receive maximum benefits. Popular plans are Blue Cross Blue Shield and John Alden Insurance. Indemnity plans usually have deductibles and in many cases the patient pays for the visit and is reimbursed by the insurance company. (See Appendix)
Malpractice insurance	An expensive liability insurance that covers medical errors.
Major medical	Insurance policy that covers catastrophic or prolonged medical care.
Most favored nation clause	A clause that allows the insurance company or Federal agency to pay at the lowest charge that the practice bills to any patient. Note: Before a practice accepts a special grant

or contract, review all Federal and insurance contracts to confirm that there is no pricing conflict.

NPI	The National Provider Identifier (NPI) will be the standard identifier for filing and processing health care claims and other transactions electronically. The numbers are issued through the National Provider System (NPS), developed by CMS. Health plans and covered entities must use the NPI by May 23, 2007 and small health plans by May 23, 2008.
Observation	A patient is brought into the hospital to be "observed". The patient can be given a bed and be monitored by nurses and doctors, usually for not more than a 24-hour time frame. The patient is NOT admitted.
Out-of-pocket limit	This is the limit of dollars that a patient will have to pay for covered services in a calendar year. For example: A patient may have a 70% coverage for hospitalization. The patient has a limit of out-of-pocket expenses of $1500. Hospital charges are $100,000. The "maximum" the patient will need to pay is $1500.
PAT	Preadmission testing. A patient has testing at the hospital before admission. The purpose is to obtain diagnostic information. Obtaining the information before admission is meant to reduce in-patient expenses and days in the hospital.
Physician's fee profile	A profile that insurance companies keep that tracts services, charges, and payments. The information can be used to determine a physician's fee schedule. The types of profiles are 1) individual customary profile and 2) prevailing profile.
Plan limit or plan maximum	This is the highest amount the insurance company will pay for medical claims during a specified period. The maximum could be on a yearly basis or for the lifetime of the policy. Often times a plan limit is dangerously overlooked when a patient is selecting an insurance coverage. For example: low costing plans may have a life-time limit of $100,000. Other plans may have a $25,000 limit per diagnosis. A plan should have a very high limit or no limit.
Pre-existing condition	Any injury, sickness, mental illness, chemical dependency, pregnancy or related illness for which a patient has seen a doctor, taken any medication, or received any medical

services or supplies during a set time before becoming covered by an insurance plan.

Precertification — Another term for “authorization” or “pre-authorization.”

Primary payer/ Primary insurance — If the patient has more than one insurance carrier, the primary payer is the carrier who is responsible for coverage before any other insurer makes a payment. When submitting to a secondary payer, a copy of the primary payer’s EOB must be attached to the claim.

Prior authorization — A procedure where the provider must submit to the insurance carrier a treatment plan before the treatment is received.

Procedure — A procedure is what the doctor does to take care of a diagnosis.

Provider identification — This is the code or number series issued by an insurance carrier to a provider. PIN stands for Provider Identification Number. NPI (National Provider Identifier) with replace the PIN.

Rider — An amendment to the subscriber’s plan that becomes part of the insurance contract and expands or limits the benefits. Example riders: dental and vision.

Second opinion — A second opinion occurs when a patient is referred to another doctor, many times the same specialty, for advice or an opinion. Most insurance carriers require a second opinion for non-emergency surgery.

Secondary payer/ Secondary insurance — If a patient has more than one insurance carrier, the secondary payer is the carrier who is responsible for payment after the primary insurer has paid its share of the costs.

S.O.A.P. — A charting procedure to write office visit chart notes. **S** stands for subjective statements. The statement is usually in the patient’s own words describing the reason for the visit. It is the chief complaint. **O** stands for objective findings. It is the data from the exam, x-rays, lab tests. It is the facts and findings. **A** stands for assessment. It represents the medical decision making to get a diagnosis.

Term	Definition
	P stands for the plan of treatment such as recommendations, testing, medication, etc.
Subscriber	An enrolled member of a health care coverage plan--also known as policyholder, insured, enrollee, or certificate holder.
Superbill or Encounter form	A patient charge slip stating the itemization of procedures, services, diagnosis, and fees.
Third-party payment	A payment made by an insurance company, attorney, friend, etc., to a health care provider to pay for medical expenses incurred by a patient.
Tracer	A form used to follow-up on an unpaid insurance claim. Also known as "claim inquiry form."
TRICARE	A managed care program implemented by the federal government for the benefit of active duty uniformed service members, spouses, dependents of service personnel, service retirees and other service eligibility beneficiaries
UCR (Usual, customary, and reasonable)	A system used to decide benefits based upon physician's prevailing fee for the locality, specialty, and service.
Waiting period	A pre-determined number of months to "wait" before coverage starts for pre-existing conditions.
Workers Compensation	An insurance contract that insures a person for on-the-job injuries or illnesses. The premiums are paid by the employer for the benefit of its employees.
Write-Off	An accounting term used to adjust a bill. In medical billing, there are several types. A contractual write-off occurs when an adjustment is made to accept the assigned value designated by the insurance company; bad-debt allowance is done to adjust the account receivables; and a professional courtesy write-off often is given to other doctors and nurses.. All write-offs need to be documented properly. The term is also known as an adjustment to an account.

Medicaid Terminology

Term	Definition
Crossover patients	Patients that have both Medicare and Medicaid coverage.
DDE	Direct Data Entry.
ICN	Interchange control number is a 13-digit number used to resubmit a claim. ICN is also known as the Medicaid Resubmission Code and Original Reference No. ICN Format (x) = number of digits Region (2) Year (2) Julian Day (3) Batch (3) Sequence (3) Adjustments and re-submittals numbers are entered on Block 22 of the Form 1500. Enter "A" before the ICN for adjustments. Enter "R" before the ICN for re-submittals. When submitting a re-submittal, include all the lines that were on the original claim. Correct the line that was denied.
MassHealth Identification	An identification card issued to MassHealth members with a 12-digit number. The Member ID will remain the same regardless of how many times the member receives a replacement card, moves to another address or has a change in marital status.
Medi/Medi claim	A combined Medicare and Medicaid claim.
Payer of last resort	Medicaid is the payer of last resort. Always bill Medicaid last. For example, a patient may have Medicare and Medicaid. Bill Medicare first. Medicare will crossover the claim to Medicaid.
Provider Online Service Center	An online web site to check eligibility, claim status, prior authorizations, and other data. To access the website, a MMIS Provider ID/Service Location number is needed. This is a 10-character provider ID consisting of nine digits and an alpha character to denote the providers location. Once the primary user has an ID, subordinate Ids for staff can be established.
Recipient Eligibility Verification System (REVS) (Web REVS)	A system available to Medicaid providers for verifying Medicaid eligibility and Managed Care enrollment. The system furnishes the following information about the Medicaid recipient: eligibility, enrollment information and third-party coverage, etc. Eligibility verification will be

supported by WebREVS, EVSpc Software, Automated Voice Response (AVR), and alternative third-party POS devices and software solutions.

The point of sale (POS) device is a small electronic transmission terminal that transmits and receives information through the telephone lines is now discontinued.

Remittance advice (RA)	A computer-generated document showing the status of all claims submitted along with a breakdown of payments. There is a list of all claims paid, pended, and denied. (Similar to EOB's). MassHealth is no longer mailing paper remittance advices. The PDF version can be viewed or printed from the Web. Claims are processed at a claim level versus the line level.
Transaction Code Number (TCN)	Replaced by ICN.This is a code number given by Medicaid for each line on a claim form submitted by a provider. This number serves as proof that a claim was submitted within the acceptable time frame required for payment.
TPL	Third Party Liability. A list of insurance carriers that are identified by a six-digit number. When required, the third-party liability carrier code is entered in Block 9 d.

Medicare Terminology

ABN	ABN (advance beneficiary notice) is known as a waiver of liability agreement. If the participating physician thinks that the services will be denied because of medical necessity or limitation of liability by Medicare, an agreement/notice must be read and signed by the patient **before** services are rendered.
Accept assignment	(For Medicare) The agreement whereby the physician or provider agrees to accept the Medicare-approved amount as full payment for services. Medicare pays 80% of the approved amount directly to the physician or provider and the patient meets the yearly deductible of $100. The patient pays the other 20%. Remember: The provider does bill the patient (or Medigap) for the 20% and must write-off the difference between the charged amount and the allowed amount. Note: If a patient is treated in the Outpatient Hospital facility, the Medicare payment to the hospital is based on hospital costs, and the patient pays 20% of the billed amount. For mental health, the coinsurance is 50%.
Approved amount	The amount Medicare determines to be reasonable for a service covered by Medicare Part B.
CMS	Centers for Medicare and Medicaid Services (CMS). Formerly known as HCFA. (www.cms.gov) The Centers for Medicare & Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA, and CLIA.
Coinsurance	The portion of the Medicare-approved amount that the patient is responsible for paying.
Correct Coding Initiative	The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of

standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the **National Correct Coding Initiative Coding Policy Manual for Medicare Services** (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers as a general reference tool that explains the rationale for NCCI edits.

The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains two tables of edits. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual.

Crossover patients — Patients that have both Medicare and Medicaid

Fee Schedule — Under a charge-based system, CMS had a policy that reduces the practice expense relative value units for certain services by 50 percent when they are performed in a facility setting. Under the resource-based system, this policy is no longer applicable because, where appropriate, CMS has developed practice expense relative value units specific to the facility and non-facility settings. Generally, under the resource-based system, the facility practice expense RVU's will be used for services performed in inpatient or outpatient hospital settings, emergency rooms, skilled nursing facilities, or ambulatory surgical centers. Non-facility practice expense practice expense relative value units will be used for services furnished in all other settings. (Medicare Compliance Manual PMIC 2002)
See www.medicarenhic.com

Formulary — Formulary is a list of drugs that a plan covers. The drugs are listed under tiers. Tier 1 has a low co-payment and represent generic drugs. Tier 2 has a co-payment higher than Tier 1 and have drugs in a preferred group. Tier 3 lists non-preferred drugs that have a higher co-payment or a percentage of full drug costs. A "S" classification represents specialty drugs.

IRS/SSA/CMS Data Match — A Federal Law (Section 1862(b) of the Social Security Act) requires the IRS, SSA, and CMS to share certain information that each agency has about Medicare beneficiaries and their spouses. The intent of the data match is twofold: to identify mistaken payments and to prevent future mistaken payments. In October of each calendar year, SSA delivers a "finder file" to the IRS. The IRS has

	40 business days from the date of receipt to match this finder file against its tax records. After receiving the results of the match, SSA has another 40 days to produce the "Data Match Employer/Employee File for CMS. The COBC (Coordination of Benefits Contractor) reviews and analyzes these data in preparation of use in contacting employers concerning possible periods of insurance primary to Medicare. The purpose of the Data Match is to identify those periods where Medicare is the secondary payer.
Limiting charge	The maximum amount a nonparticipating physician may charge a Medicare patient for a covered physician service.
Mandatory Assignment	Medicare requires that assignment be accepted for the following services: clinical diagnostic laboratory services, Medicare patients who are also Medicaid patients, ambulatory surgical center services, services provided by non-physician practitioners, such as nurse practitioners, physician assistants, etc.
Medically Unlikely Edits	The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE.
Medi/Medi claim	A combined Medicare and Medicaid claim.
Medicare Part A	Medicare Hospital Insurance. This insurance helps pay for medically necessary inpatient care in a hospital, psychiatric hospital, skilled nursing facility, and hospice and home health care.
Medicare Part B	Medicare Medical Insurance. This insurance pays for medically necessary physician services and many other medical services and supplies not covered by Part A.
Medicare Part C	Known as Medicare Plus (+) and Choice plans. Part C offers insurance plan options for Medicare participants. The plans may include HMOs, fee-for-service, provider sponsored associations, and Medicare savings accounts.
Medicare Part D	Medicare Part D is the Medicare drug plan. It is an insurance plan that helps cover the cost of prescription

	drugs. This plan can be a stand-alone insurance or incorporated with a Medicare Health plan or Medicare Advantage plan.
Medicare carrier	An insurance organization under contract to the federal government to process Medicare Part B claims.
Medicare Secondary-Payer Plan (MSP)	When there is an insurance plan that is primary to Medicare, Medicare is billed as the secondary-payer. A copy of the primary EOB must be submitted with the Medicare claim.
Medigap	Also known as supplemental insurance. This insurance covers the patient's Medicare deductible and copayments. Popular supplemental insurances are: MEDEX, AARP, HMO supplements, and Medicaid.
Relative Value Units (RVU)	A number assigned to represent a value of a service. The units are called "relative" because the numbers are assigned on the basis of how one service compares to another.
Unique Provider Identification Number (UPIN)	NPI has replaced this number. This number was assigned by CMS and used on the Medicare claim form when a referring physician is stated on the claim. The UPIN was entered on line 17a on Form 1500. The UPIN system was established in 1989 to track and maintain physicians' profile and performance records. The physician kept the same number even if he/she moved to another state. Nonpayment of a claim would result if the UPIN was omitted.

HMO, PPO, IPA and PPG Terminology

Term	Definition
Capitation	A method of payment for medical services where the provider is paid a fixed fee for each person served in a set period of time. The payment is on a per capita basis and has no relationship to the type of services performed or the number of services of each patient.
Closed-panel HMO	A program where patients receive non-emergency health services from contracted providers at a specified facility.
Co-payment	A specified dollar amount that the patient pays each time he/she visits a provider's office. A provider can collect a co-payment from the patient at the time of the visit. However, if a patient has 80% (or other percentage) coverage, the provider usually bills the managed care company first and then bills the patient the plan percentage of the allowed amount. This term should not be confused with the term coinsurance.
Exclusive provider organization (EPO)	A closed-panel PPO plan where the patient receives no benefits if he/she receives care from a provider that is not a member of the EPO.
Gatekeeper	Gatekeeper also known as the Primary Care Physician.
Group model HMO	An HMO that contracts with an already existing multi-group practice. The group provides all services for the HMO. The providers could either work exclusively for the HMO and treat patients within the plan's facilities or in other cases, could accept private, non-HMO patients and see both categories of patients in their private offices.
Health Maintenance Organization	The medical organization or group of physicians and hospitals who agree to provide health care services to members for a specific prepaid fee. A HMO member must select a Primary Care Physician (PCP) who will coordinate the member's care. HMO's are often thought of as an insurance company. However, they are not, and therefore follow different state laws.

In network	In-network services are provided by a provider who has signed a contract with a HMO or PPO and agrees to be in that plan's network. When a patient uses an in network provider, the patient receives full benefits under his/her plan and minimizes out-of-pocket expense.
Individual Practice Association (IPA)	A group of individual medical providers that join together to provide a prepaid health care program. The physicians are paid fees for their services out of funds drawn from the premiums collected by the HMO that markets the health plan minus a discount to cover operating costs. At year-end, the physician's share in any surplus or pay part of any deficit. The risk-taking serves as an incentive to keep medical costs down.
Managed care	A system for operating an insurance program by controlling the utilization of services. The system assigns patients to specific case managers who are responsible for prospective and retrospective review of the physicians' treatment plans and the patient's discharge planning to ensure that treatment for the patient's medical condition is given in the most appropriate setting and in the most cost-effective way.
MCO	Initials for managed care organizations.
Nonparticipating provider (Non-PAR)	A provider that has not signed a participating provider contract with an insurance carrier. The Non-PAR provider bills the patient for the difference between the amount charged for the service and the allowed fee as determined by the insurance company.
Open-panel HMO	This HMO plan does not require preauthorization by the HMO PCP if the patient self-refers to a specialist who is not a member of the HMO. The patient will, however, pay a large deductible and co-payment before the HMO will reimburse the patient for care received from the non-HMO specialist.
Out-of network	Out-of-network services are given by a provider who has not signed a contract with the patient's health plan and is not in that plan's provider network.

Participating provider (PAR)	A health care provider who has entered into a contract with an organization to provide medical care to subscribers. The provider will accept the insurance company's approved fee for each medical service and bill the subscriber for only the deductible, co-payments, and any uncovered services as stated in the subscriber's policy.
Payer of last resort	An insurance company that is billed only when there are no other medical benefits, or if the patient's other coverage denies responsibility for some or all payment or have lower payment schedules for benefits covered by the payer of last resort.
POS (Point of Service)	A plan that is either an HMO or PPO that allows patients to choose between using the network or non-network providers whenever they need medical care. The subscriber selects a PCP to coordinate all medical care.
PPO (Preferred Provider Organization)	Patients under this plan are given the choice of having services from an in-network provider at a higher level of benefits, or from an out-of-network provider at a reduced level of benefits. A PPO member does <u>not</u> have to select a Primary Care Physician to coordinate his/her care.
Primary Care Physician	In an HMO, the PCP is the doctor the patient has selected to be the main health care provider. The PCP is responsible for treating and referring the patient to specialists.
Professional Review Organizations (PROs)	The professional review is a peer review where one or more physicians working with the federal government under federal guidelines evaluate another physician in regard to the quality of professional care, to settle disputes on fees or to examine evidence for admission and discharge of a hospital patient. PROs are not restricted to only HMO programs but also play a role in Medicare inpatient cases.
Referral	In managed care plans, a patient's Primary Care Physician is responsible for coordinating care. If a patient needs services the Primary Care Physician cannot provide, the PCP refers the patient to another network provider. The PCP must submit a referral to the insurance company. In

	some cases, the insurance company must have a written referral, in other cases, the company will accept a "phone in" referral.
Referring physician	The physician who sends the patient to another physician or other provider for consultation or treatment.
Silent PPO	Also known as phantom PPOs or discounted indemnity plans. Silent PPOs occur when preferred provider payers buy existing preferred provider networks without informing providers who have signed a contract. In other cases, payers make fee adjustments associated with contract PPOs in the hopes that providers will not notice the adjustment to payments.
Withold:	Withholds are a percentage of the monthly capitation payment held until the end of the year. If the provider does not go over budget, the amount plus interest is returned to the provider. If services were used over budget, the payer keeps the withholds. Thus, providers share the risks of profit and loss. Withhold is a system to limit referrals and tests in order to keep costs down.

High Deductible Plans, HSAs, and HRAs

Overview

The Modernization Act of 2003 authorized the establishment of new Health Savings Accounts, effective January 1, 2004. The HSAs permit eligible individuals to save for, and pay, health care expenses on a tax-free basis.

HSAs are high-deductible insurance plans *with* a qualified savings account that is set up with a trustee (a bank, an insurance company, or anyone already approved by the IRS to be a trustee of individual retirement arrangements). Not all deductible plans qualify as Health Savings Accounts. Consequently, the practice will have patients with regular deductible plans and those with a Health Savings Account or with a Health Reimbursement Arrangement (HRA). Additional information is provided below.

High-Deductible Plans

Three common high-deductible plans are—Traditional, PPOs, and HMOs.

Traditional High-Deductible Plans

These are straightforward. Often, the plans are expressed as an "80/20 with $1000+ deductible," meaning that the insurance company pays 80 percent and the patient pays 20 percent (after a $1,000 deductible paid by the patient). (Note: Deductibles and benefit percentages vary in the above example.)

This plan offers the most flexibility because members have no restrictions regarding specific networks and referrals in order to receive maximum benefits. The plan usually offers an out-of-pocket maximum. Often, physicians are paid based on the provider's fee schedule or usual, customary, and reasonable (UCR).

Payment Collection: Depending on the practice's policy and financial arrangement with the patient, obtain a signed assignment of benefits.

PPO High-Deductible Plans

Deductibles and benefit coverage for these plans vary within "in-network" and "out-of-network". Selecting a primary care physician and obtaining referrals are *not* required. For in-network services, after a deductible is met, the member is responsible for a co-pay. For out-of-network services, the deductible is higher and, instead of a co-pay, the member pays a coinsurance, which is usually stated in percentages similar to the traditional high-deductible plans. Note: The deductibles are *separate* for in-network and out-of-network.

Some plans offer in-network preventive care benefits not subject to calendar year deductibles, but a co-pay applies. Some plans offer coverage for most office visits

(excluding specialists) which are not subject to calendar year deductibles. This arrangement is known as a "carve out". Usually, the plan offers an out-of-pocket maximum. Physicians may be paid based on their fee schedule, usual, customary, reasonable (UCR), or a contracted rate.

HMO High-Deductible Plans

Members with these plans have a deductible and are required to choose a primary care physician (PCP). Similar to non-deductible HMO's, the PCP will provide or arrange for health services. Referrals are required for most specialty care. Generally, this plan offers in-network preventive care benefits that are not subject to calendar year deductibles. Depending on the contract, a plan may also offer coverage— not subject to calendar year deductibles—for office visits, excluding specialists.

Except for emergencies, medical care requires PCP approval and, in some cases, approval by an authorized reviewer. Other than emergency and urgent care, services outside the network are not usually covered. Usually, this type of high-deductible plan offers an out-of-pocket maximum. Physicians are paid based on a contracted rate.

Health Savings Account

HSAs, are funds *set aside in an account* to pay for deductibles associated with *high-deductible insurance plans*, such as those plans mentioned above—they must follow Federal set up and implementation rules in order to be considered tax qualified. The *minimum* deductible allowed is $1,000 for a single person and $2,000 for a family. The amounts are indexed for inflation. (Check current year minimum and maximum.)

HSAs provide tax savings to the employee and employer. With the cost-sharing method, the insurance premiums are lower. Generally, an employee and/or employer contribute to the *employee's qualified* savings account to cover payments of a deductible. Contributions to the savings account are subject to limits. The employee owns the account and *may* use the funds to pay for qualified medical expenses, deductible and coinsurance responsibilities.

Patients with HSAs will have *no* other health coverage. Note: With the following exceptions: Workers' compensation, specific disease or illness, a fixed amount per day of hospitalization, accidents, disability, dental, vision, and long-term care.

Some high-deductible plans may provide preventative care benefits and/or a prescription rider without a deductible or with a deductible below the minimum annual deductible.

Payment Collection: Follow the guidelines of the insurance plan. See the terminology for benefit cards, deductibles, coinsurance, and co-pay listed below.

Health Reimbursement Arrangements

(HRAs) are *combined* with an insurance plan—often a high deductible plan. They are tax-favored, set up and paid for by the *employer*. The employer reimburses a portion of each employee's medical expense (usually, part of the deductible). The employer, an insurance company, or third-party administrator may administer a reimbursement plan.

Payment Collection: First, submit the claim to the insurance company to find out the patient's financial responsibility. The balance due may be subject to allowable and contracted rates. In some cases, the claim works similar to a "crossover" for a secondary insurance claim. The insurance company will forward the claim information to the third-party administrator.

In other cases, after submitting the claim to the insurance company and receiving an EOB or EOP, the medical office can submit the bill directly to the third-party administrator or directly to the patient

In addition, a patient may have a <u>benefit card</u> to pay for the claim.

For detailed information on HRAs and HSAs, please see IRS Publication 969.

Terminology

<u>Assignment of benefits</u> is an agreement signed by the insured giving permission for the benefits (payments) to be issued to the provider of services.

<u>Benefit cards</u> are credit card based, debit cards. For HRAs, the employer deposits an amount (determined by the employer) to the card. The employee may use the card to pay for medical services and other medical expenses. For HSAs, an employer and employee may (or may not) make deposits to the card's account.

The cards *may* be used to pay for services *after* the insurance company has notified the practice and patient of the contracted rate and the patient's financial responsibility.

The benefit cards are independent from the insurance company. The insurance company and the practice will not have access to benefit card account information.

Note: On account statements to patients, include a section where the patient can write their benefit card account number information.

<u>Calendar Year:</u> For deductible tracking, the calendar year begins January 1 of any year through December 31 of the same year. Some plans allow deductible carry-over credit—

which are charges applied to the deductible for services during the last three months of a calendar year that are used to satisfy the following year's deductible.

Coinsurance is the portion of covered health care costs for which the covered person has a financial responsibility, usually a fixed percentage. Coinsurance usually applies after the insured meets his /her deductible or goes outside the plan's network.

Payment Collection: See deductible.

Co-payment is a cost-sharing arrangement. The insured pays a specified dollar amount for a specific service, such as $10 for an office visit. This charge may be in addition to certain coinsurance and deductible payments. For example, once a deductible is met, the service requires a co-payment from the insured. Generally, co-payments do not apply towards the deductible and may or may not apply towards the annual out-of-pocket maximums. (Note: Some policies have substantially increased the co-payments ($100+) for each emergency room care, hospitalizations, and day surgery.)

Payment collection: The patient's co-pay responsibility is listed on the patient's insurance ID card should be collected at the time of service. For admissions, surgery, and emergency room services, hospitals may need to wait until after they submit the bill to the insurance company to determine whether a co-pay or deductible applies.

Deductible is the amount of eligible expenses a covered person must pay each year from his/her own pocket before the insurance plan will make payments for eligible benefits. In some cases, a deductible does not apply to certain in-network preventive medical services. Some contracts may include an additional separate calendar-year deductible for prescription drugs—this deductible does not count towards the main deductible. A plan may state the deductible as "per member" or "family".

Payment Collection: Generally, patients are not required to make a payment for services until they receive a notice, an explanation of benefits or explanation of payments (EOB or EOP) from the insurance company stating the negotiated rate and the patient's financial responsibility. *Collection policies vary.* For example, some companies require the medical practice to submit a claim first, others strongly suggest it, and others advise their members not to pay at the time of service. Collecting at the time of service can result in receiving an overpayment from the patient causing the obligation to send a refund check.

Insurance companies pay as claims are approved—regardless of the date of service or the order in which they are submitted.

Explanation of benefits (EOB) is also know as a remittance advice or explanation of payment (EOP). The form is sent by the insurance carrier at the time of reimbursement or rejection of a claim. It is an explanation of how the claim is settled. They usually state the amount allowed for the service and the patient's obligation.

Fee-for-service is a method of billing whereby the provider bills for each visit or service rendered rather than an all-inclusive or prepaid fee basis.

In-network services are rendered by a provider who has signed a contract with an HMO, POS or PPO and agrees to be in that plan's network. When a patient uses an in-network provider, the patient receives full benefits under his/her plan and minimizes out-of-pocket expenses.

Out-of network services are given by a provider who has not signed a contract with the patient's health plan and is not in that plan's provider network.

Out-of-Pocket Maximum or Out-of-Pocket Limit is the total amount that must be paid by a covered person before covered health services are paid at 100% by the insurance company for the rest of that calendar year. (Note: Most companies do not include deductibles in the maximum total.)

Rider is an amendment to the subscriber's plan that becomes part of the insurance contract and expands or limits the benefits. Examples of riders: dental and vision.

UCR (Usual, customary, and reasonable) is a system used to decide benefits based upon physician's prevailing fee for the locality, specialty, and service.

Laws and Agencies

The following is a brief description of a few laws that are common in the medical industry. In many cases, the laws contain over 50 pages of text. Compliance is mandatory.

HIPAA: Health Insurance Portability and Accountability Act. The purpose of the act is to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes such as privacy of medical information. See http://answers.hhs.gov

The Act gives the Department of Health and Human Services (HHS) the authority to define regulations related to privacy and security. It includes administrative procedures, physical safeguards, technical security, guarding data and the prevention of unauthorized access.

The Privacy Rule applies to “individually identifiable health information transmitted or maintained by a covered entity, regardless to form”. The Rule creates national standards to protect individuals’ medical records and other personal health information; gives patients more control over their health information; sets boundaries on the use and release of health records establishes appropriate safeguards to protect the privacy of health information; holds violators accountable, with civil and criminal penalties strikes a balance when public responsibility requires disclosures for some forms of data.

The Security Rule applies to Electronic Protected Health Information (PHI) and includes: creating, receiving, maintaining and transmitting data; all media—magnetic tape, disk, or other machine readable media such as transmissions—over the Internet, extranet, leased and dial-up lines and private networks.

There are six main sections:

164.306: Security Standards: General Rules
164.308: Administrative Safeguards
164.310: Physical Safeguards
164.312: Technical Safeguards
164.314: Organizational Requirements
164.316: Policies and Procedures and Documentation Requirements

The purpose of the Security Rule is to maintain reasonable and appropriate administrative, technical, and physical safeguards; ensure integrity and confidentiality of information; and protect against any reasonably anticipated threats or hazards to the security against unauthorized uses or disclosures

Stark II: Incorporated into Section 1877 of the Social Security Act, if a physician or a member of a physician's immediate family has a financial relationship with a health care entity, the physician may not make referrals to that entity for the furnishing of designated health services (DHS) under the Medicare program, unless an exception applies. The following services **are** DHS: clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

Anti-kickback: Section 1128(b) of the Social Security Act (42 U.S.C. 1320a-7b(b) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce business reimbursed under the Medicare or State health care programs. The offense is classified as a felony and is punishable by fines of up to $25,000 and imprisonment for up to 5 years.

The provision is extremely broad. The types of remuneration covered specifically include kickbacks, bribes, and rebates made directly or indirectly, overtly or covertly, or in cash or in kind. In addition, prohibited conduct includes not only remuneration intended to induce referrals of patients, but remuneration also intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by Medicare or State health care programs.

The Centers for Medicare & Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA, and CLIA.

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