Medical Claims Glossary

Weston Distance Learning®

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New Medical Claims Glossary

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A

ABN (Advance Beneficiary Notice)	Medicare requirement that informs the patient of the procedure and explains why it is not covered.
accident	An unplanned or unexpected happening that causes injury or death not due to any fault of the employee.
actual charge	The amount the physician actually charges on the Medicare claim.
adjustments	Corrections reflecting changes on a previously submitted claim; the corrections may result from overpayment or underpayment.
Advance Beneficiary Notice (ABN)	Medicare requirement that informs the patient of the procedure and explains why it is not covered.
aging	An insurance term that shows how long a payer has taken to respond to an insurance claim; it usually indicates an unpaid claim.
allowable charge	The maximum amount an insurance carrier will pay for a specific service when the physician is a participating provider in the program.
ambulatory payment classifications (APCs)	Classification system designed to specify the amount and type of resources used for each outpatient visit.
amount due from insurance carrier	The amount the insurance carrier will pay for the medical service.
amount due from patient	Depending on the insurance policy, the amount that is the difference between either (1) the total charge or (2) the allowable charge and the total amount due from all insurance carriers for services the patient's contract covers.
amount paid by other carrier	The portion of covered services due from another insurance carrier if the patient is covered by more than one policy.
appeals letter	A document that details the claim filed, the action taken and why you consider the reimbursement to be incorrect.
approval	Occurs when an original claim or a previously denied claim is approved for payment.
approved charges	Charges that help to determine Medicare payments.
audit/refund transactions	Miscellaneous transactions related to cost settlements, state audits or refund checks received.

authorized provider	A physician, hospital, clinic or supplier who has applied and been approved to provide medical care and supplies.
automatic crossover	Process in which the primary carrier handles the coordination of benefits transaction by sending the secondary carrier the primary claim information electronically.

B

beneficiaries	The family members of service members who have TRICARE.
benefits	Payments an insurance carrier pays for medical treatment based on a policy.
benefits paid	The amount the insurance carrier has reimbursed for the services charged by the physician.
birthday rule	An accepted policy that the health insurance industry has widely adopted for the coordination of benefits when children are listed as dependents on two parents' group health plans. This rule states that the dependent's primary policy is the one covering the parent whose birthday occurs first in the calendar year.

C

capitation	The physician receives a set dollar amount determined by per member per month calculations to deliver medical services to a specified group of people.
carrier (insurer)	An insurance company.
carrier-direct submission	Process through which the provider files directly to insurance companies.
catastrophic cap	An annual upper limit a family will have to pay for TRICARE Standard covered services in any fiscal year.
Category I codes	All of the "regular" CPT codes in the six main sections of the manual.
Category II codes	A special collection of CPT codes that providers use to track and measure performance internally.
Category III codes	Temporary codes.
Centers for Medicare & Medicaid Services (CMS)	A branch of the U.S. Department of Health and Human Services (HHS).
CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)	Program established in 1966 to provide healthcare coverage for families of members of the uniformed services.

CHAMPVA (Civilian Health and Medical Program of the Veterans Administration)	Program that provides health care for families of veterans with permanent, service-connected disabilities.
Children's Health Insurance Program (CHIP)	Program that provides free or low-cost health insurance coverage to children up to age 19 who are ineligible for Medicaid but can't afford private insurance.
CHIP (Children's Health Insurance Program)	Program that provides free or low-cost health insurance coverage to children up to age 19 who are ineligible for Medicaid but can't afford private insurance.
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)	Program established in 1966 to provide healthcare coverage for families of members of the uniformed services.
Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)	Program that provides health care for families of veterans with permanent, service-connected disabilities.
claim amount	The amount from field 28 of the CMS-1500 form.
claim date	Date listed in field 24A of the CMS-1500 form.
claim form	The document that is completed and submitted to an insurance carrier to request reimbursement for services rendered.
clean	A claim without errors.
clearinghouse	A company that facilitates the processing of claims information into standardized formats, then submits the claims to the appropriate insurance companies.
CLIA (Clinical Laboratory Improvement Amendment)	A government agency that regulates how lab procedures are performed.
Clinical Laboratory Improvement Amendment (CLIA)	A government agency that regulates how lab procedures are performed.
CMS (Centers for Medicare & Medicaid Services)	A branch of the U.S. Department of Health and Human Services (HHS).
CMS-1500	The standard claim form used to request payment for services rendered by the healthcare provider.
COBRA (Consolidated Omnibus Budget Reconciliation Act)	Program designed to provide health insurance coverage to those who become unemployed either voluntarily or involuntarily, and to those who no longer qualify for health insurance benefits because of a reduction in hours.

coinsurance/copayment	The patient's payment of a portion of the cost at the time of receiving the medical service.
confidential	Secret.
Consolidated Omnibus Budget Reconciliation Act (COBRA)	Program designed to provide health insurance coverage to those who become unemployed either voluntarily or involuntarily, and to those who no longer qualify for health insurance benefits because of a reduction in hours.
conversion factor	A numerical factor, or dollar amount, used to convert the total RVUs into a payment amount to reimburse the provider.
COB (coordination of benefits)	Policy that applies to a person who has coverage under more than one health plan; the COB provision and regulations require that all health plans coordinate benefits to eliminate duplication of payment.
collection agencies	Businesses that specialize in collecting unpaid debts for other businesses.
comments	Section on an insurance claims log to fill in when doing follow-up.
compliance	Ensuring that a company or facility provides and bills for services according to the regulations, laws and guidelines that govern it.
coordination of benefits (COB)	Policy that applies to a person who has coverage under more than one health plan; the COB provision and regulations require that all health plans coordinate benefits to eliminate duplication of payment.
copayment	A flat amount that the insurance policy designates a patient must pay before leaving the doctor's office.
cost-share	The percentage paid by the patient enrolled in TRICARE Standard and Extra of the allowable charges for health care for each claim.
credit	A merchant's acceptance of your promise to pay later for goods or services you receive immediately.
credit agreement	The terms of credit, including the method and amount of payment required, payment due dates and consequences for missed payments or other problems.
credit report	Report that lists all of your credit accounts and your payment history with those accounts.
creditor	The person or business who issues the credit.
customary	The amount that most physicians in the community normally charge for a service.
customary charge	The amount a physician would normally charge for a specific service.
customary maximum	The fee charged by most providers in the community.

D

database	A structure that stores organized information.
date benefits paid	Date when payment is received from the insurance carrier.
DD Form 2527	A personal injury statement about how the accident happened.
death of a worker	The most serious on-the-job injury category; applies for cases in which the employee is killed during the course of employment.
debtor	The person or business who receives credit.
deductible	The amount of money an individual must pay before insurance benefits begin; the amount the patient enrolled in TRICARE Standard and Extra must pay each fiscal year before TRICARE begins sharing the cost (cost-share) of medical health care.
DEERS (Defense Enrollment Eligibility Reporting System)	A computerized data bank that lists all active and retired military members, as well as their dependents.
default judgment	Court decision in which the person who appears wins.
defendant	The person against whom you are filing a legal action.
Defense Enrollment Eligibility Reporting System (DEERS)	A computerized data bank that lists all active and retired military members, as well as their dependents.
delinquent account	Any account for which the debtor has failed to live up to the credit agreement.
denials	Denied claims. Denials occur when the health insurance company receives and processes a claim, but determines that the treatment in question is not a covered benefit in the plan.
denied for payment	A claim submitted to an insurance carrier for which payment has been rejected due to a technical error or medical coverage policy issues.
diagnosis	The physician's opinion about what's wrong with the patient.
diagnosis related groups (DRGs)	A diagnosis-specific prospective payment system (PPS) for inpatient hospital services.
digitized	Data entered into a computer record.
direct deposit	The process through which money is electronically deposited into a bank account.
DRG monitor	An individual who reviews current fee schedules and compares them to a current list of DRGs to make sure fees are in line with the DRGs.
DRGs (diagnosis related groups)	A diagnosis-specific prospective payment system (PPS) for inpatient hospital services.

E

EHR (electronic health record)	A computerized record of the patient's health status.
EIN (employer identification number)	Number used for 1099 taxable income reporting purposes.
electronic claims	Digitized insurance claims transmitted from a computer, using a modem, to the insurance company or clearinghouse.
electronic health record (EHR)	A computerized record of the patient's health status.
employee	A person who is hired to work for another.
employer identification number (EIN)	Number used for 1099 taxable income reporting purposes.
encounter form (face sheet)	Form that contains the patient information (name, address, date of birth), insurance information (carrier, policy number), physician information (provider, billing information) and the diagnosis and procedure codes for the specific date of service.
EOB (explanation of benefits)	The document that explains the benefits provided, as well as the reason why benefits were not provided.
EOMB (Explanation of Medicare Benefits)	Document from Medicare that includes the amount billed, amount approved, deductible and/or coinsurance that the patient is responsible to pay.
event billing	Billing method that generates a bill every time something on the patient's account is activated.
excess charges	Any charges higher than the amount allowed by Medicare for a specific covered service.
explanation of benefits (EOB)	The document that explains the benefits provided, as well as the reason why benefits were not provided.
Explanation of Medicare Benefits (EOMB)	Document from Medicare that includes the amount billed, amount approved, deductible and/or coinsurance that the patient is responsible to pay.

F

face sheet (encounter form)	Form that contains the patient information (name, address, date of birth), insurance information (carrier, policy number), physician information (provider, billing information) and the diagnosis and procedure codes for the specific date of service.
FECA Blk Lung	An insurance plan that provides insurance for government employees who have been injured on the job.
federal compensation laws	Laws that cover miners, maritime workers and civilian employees of the federal government.

fee-for-service	A method of charging in which a provider bills for each encounter or service she rendered.
fee schedule	A predetermined dollar amount that the third-party payer allows for payment of a particular healthcare service.
fields	The numbered spaces on the CMS-1500 claim form.
filing date	Date the claim is actually sent to the insurance company.
First Report of Injury	Form that gathers information regarding the injury, the patient, the employer and the physician's initial assessment.
first treating physician	The provider who first diagnosed and treated the injury.
first-party payer	The patient, or the person responsible for the patient's health bill.
fiscal agents	Organizations under contract with the government to handle claims from physicians and other suppliers of services covered under Medicare Part B.
fiscal intermediaries	Organizations under contract with the government to handle claims from hospitals, skilled nursing facilities, long-term care facilities and home health agencies.
fixed fee schedule	The maximum fee allowed by the insurance company for a specific medical service or procedure.
FLs (form locators)	The data fields on the UB-04 claim form.
follow-up date	Date 30 days after the filing date.
Form CA-1	The FECA form for a traumatic injury.
Form CA-2	The FECA form for an occupational illness.
Form CA-16	The FECA form that authorizes treatment for the first 60 days.
form locators (FLs)	The data fields on the UB-04 claim form.

G

geographic practice cost index (GPCI)	The geographic adjustment for the nationally uniform relative value.
global payment method	The third-party payer makes one combined payment to cover the services of multiple providers for a single episode of care.
GPCI (geographic practice cost index)	The geographic adjustment for the nationally uniform relative value.
group health insurance	Insurance plan in which the insurance carrier cannot deny coverage to any of a company's employees, regardless of pre-existing conditions.
group health plan	A plan in which a group of people participate on a single policy; this is generally the case when a business provides health insurance as a benefit for its employees.
guarantor	Someone who is responsible for an account.

H

HCPCS Level II codes	Five-digit, alphanumeric codes for physician and nonphysician services that the CPT manual does not cover.
HDHP (high-deductible health plan)	A health insurance plan in which the insured anticipates paying the first dollar medical expenses; in other words, the plan includes a very high deductible.
health maintenance organization (HMO)	A prepaid health plan in which individuals receive medical services from participating providers.
Health Savings Account (HSA)	Account established so that individuals covered by high-deductible health plans could receive tax-preferred treatment of money saved for medical expenses.
high-deductible health plan (HDHP)	A health insurance plan in which the insured anticipates paying the first dollar medical expenses; in other words, the plan includes a very high deductible.
HMO (health maintenance organization)	A prepaid health plan in which individuals receive medical services from participating providers.
HSA (Health Savings Account)	Account established so that individuals covered by high-deductible health plans could receive tax-preferred treatment of money saved for medical expenses.

I

ICD indicator	Identifies the ICD code set being used.
inpatient	Someone admitted to the hospital to stay overnight.
insurance	A contract between an insurance company and an individual or group.
insurance carrier	Carrier name from field 11c of the CMS-1500 form.
insured	An individual or group contracted for insurance.
insurer (carrier)	An insurance company.
invoice paid date	Date the payment is received from the patient.

J

judgment	Decision that outlines how much the defendant owes, and when the court case took place.

L

legal disability	A disability that meets the requirements of a particular insurance program.

M

major diagnostic categories	DRG classifications that are usually based on a specific organ system of the body.
malpractice expense	Represents the cost of the malpractice insurance premium to provide the service or procedure; it accounts for four percent of the total relative value.
Medicaid	A federally mandated program that provides medical and health-related services to those who cannot afford them.
medical bill	A request for reimbursement.
medical billing specialists	Professionals who gather information to complete insurance forms.
medical claims with no disability	On-the-job injuries that are easy to treat, and the employee is expected to return to work within a short duration of time.
medical coder	Professional who assigns numeric or alphanumeric codes to identify the problem or condition and what the physician did during that office visit.
medical coding	The translation of medical record documentation of illnesses, diseases, injuries, treatments and procedures into numeric and alphanumeric characters.
medical disability	A condition that disables the person, such as a severe back injury.
medical insurance	Also known as health insurance or healthcare coverage, this is a contract between an insurance company and the insured for medical benefits.
medical record	Record that contains patients' medical history related to that specific provider's office.
medical transcriptionist	Professional who transcribes the encounter into a formatted medical record.
Medicare	A federally funded program that provides health insurance for those older than age 65 and persons with disabilities.
Medicare Advantage Plan (Medicare Part C)	Plan that Medicare-approved private companies offer.
Medicare Part A	Medicare program that helps pay for medically necessary inpatient care in a general hospital, skilled nursing facility care, home health care, hospice care and blood (during a covered stay).
Medicare Part B	Medicare program that helps pay for medical expenses, clinical laboratory services, home health care, outpatient hospital treatment and blood, if medically necessary.

Medicare Part C (Medicare Advantage Plan)	Plan that Medicare-approved private companies offer.
Medicare Part D	Program Medicare implemented to include prescription drug coverage.
Medigap	Coverage usually purchased from a third-party private insurance company to fill the gaps in Medicare.
Medi-Medi	Plan for people who have both Medicare and Medicaid coverage.
MedLook	A medical billing software program.
minimum standards	Requirements that indicate that each participant in Medicaid must receive certain aspects of care.

N

narrative explanation	A further explanation of procedures, diagnoses or other information on a claim.
NAS (nonavailability statement)	A certification from the uniformed service hospital that the procedure the patient is seeking is not available at the military facility.
National Plan and Provider Enumeration System (NPPES)	Mandate that collects identifying information on healthcare providers and assigns each a unique National Provider Identifier (NPI).
nationally uniform relative value	Fee calculation value based on physician work, practice expense and malpractice expense.
negative credit information	Harmful information on a credit report, such as late payments, bankruptcies or defaults.
network provider	The physician who provides medical care and services to TRICARE beneficiaries under the TRICARE Extra program at contracted rates.
nonavailability statement (NAS)	A certification from the uniformed service hospital that the procedure the patient is seeking is not available at the military facility.
non-PAR	A physician who does not participate with Medicare.
NPI	A 10-position, intelligence-free numeric identifier (10-digit number).
NPPES (National Plan and Provider Enumeration System)	Mandate that collects identifying information on healthcare providers and assigns each a unique National Provider Identifier (NPI).

O

Office of Workers' Compensation Programs (OWCP)	Office of the United States Department of Labor that administers coverage of the federal workers' compensation laws.
on-the-job injury	Type of injury required for a worker to qualify for workers' compensation benefits.
order of garnishment	A legal document requiring the defendant's employer to withhold a percentage of the defendant's pay each month and send that money to the plaintiff.
outliers	Cases that require patients to have additional time in the hospital, variations in treatments or other unusual circumstances.
outpatients	Patients who receive treatment but don't necessarily need to stay for a 24-hour period at a medical facility.
outstanding	Bills that haven't been paid yet.
OWCP (Office of Workers' Compensation Programs)	Office of the United States Department of Labor that administers coverage of the federal workers' compensation laws.

P

PAR	A physician who participates with Medicare.
participating providers	Physicians who enter into contracts with specific companies; healthcare providers who participate in TRICARE.
parties	Both the plaintiff and the defendant in a lawsuit.
patient name	Name from field 2 of the CMS-1500 form.
patient responsibility/ refund	If the provider is not a preferred provider, the patient will be responsible for this amount, in addition to any deductible and copayment due.
PAYERID	A unique, eight-digit number assigned to each healthcare payer; it is used in electronic claims to route the secondary claim automatically.
PCM (primary care manager)	Representative chosen or assigned for people enrolled in TRICARE Prime; this person will provide and coordinate all healthcare needs.
peer review organizations	Also called professional review organizations, these consist of physicians who evaluate physicians in managed care situations to make sure their patients are receiving proper care.
pending (suspense)	The claim is in review or the insurance carrier is waiting for additional information.
per member per month (PMPM)	The amount of money paid each month for each individual enrolled in the health insurance plan.

permanent disability	An on-the-job injury that involves the permanent disability of the employee.
physician provider group (PPG)	Type of managed care in which physicians own the group.
physician work	The largest cost element of the nationally uniform relative value; it includes the physician's time, mental effort, technical skill, judgment, stress and an amortization of the physician's education.
plaintiff	The person filing the legal action, or suing the defendant.
PMPM (per member per month)	The amount of money paid each month for each individual enrolled in the health insurance plan.
point of service (POS)	Plans that strive to combine the best elements of both HMOs and PPOs, consisting of participating physicians and hospitals.
policy	Contract that states that the insurance carrier will pay some or all of the medical bills of the insured in the case of certain injuries or illnesses.
POS (point of service)	Plans that strive to combine the best elements of both HMOs and PPOs, consisting of participating physicians and hospitals.
PPG (physician provider group)	Type of managed care in which physicians own the group.
PPOs (preferred provider organizations)	Plans in which members can choose their own providers and treatment facilities.
practice expense	The second element of the nationally uniform relative value; it represents the practice overhead and accounts for 44 percent of the total relative value.
preauthorization	The process of notifying an insurance company before hospitalization, surgery or tests.
preferred provider organizations (PPOs)	Plans in which members can choose their own providers and treatment facilities.
premiums	Payments the insurance carrier collects from the insured.
prepay	Paying in advance for coverage of specified services should the need for those services arise.
prevailing charge	An amount based on customary charges of physicians in the same geographical area; charge that reflected the average, or median, charge of a cross-section of providers in similar settings, such as practice or city size, for the same service.
primary care manager (PCM)	Representative chosen or assigned for people enrolled in TRICARE Prime; this person will provide and coordinate all healthcare needs.
primary carrier	The primary insured health plan.

primary physician	A provider who is in charge of a particular patient.
prior patient payment	Payment amount from field 29 of the CMS-1500 form; the amount of any deductible and/or coinsurance the patient has paid.
private health insurance	Coverage that offers a variety of healthcare plans requiring the subscriber to pay premiums.
procedure	Anything the physician does to determine a diagnosis and treat a patient.
professional liability insurance	Insurance that protects you if anyone sues you for malpractice.

Q

questionnaire	Document that asks about a patient's medical history, insurance coverage and other important facts.

R

RA (remittance advice)	Explains the payment decisions to the provider.
RBRVS (Resource Based Relative Value System)	Fee calculation that factors several elements into the nationally uniform relative value; the calculation includes a geographic adjustment and conversion factor.
reasonable	Factor based on the appropriateness of the charge, considering all circumstances.
reciprocity	The process of a home state paying a claim for a medical situation that occurred in another state.
referral	An authorization by one provider for a patient to see another provider for a specific health problem.
reimbursement	A healthcare term that refers to compensation or repayment for healthcare services.
rejected	A claim returned to a provider, often for a correction or change, so that it can be processed properly for payment.
relative value unit (RVU)	Unit of measurement assigned to the medical service based on the relative skill and time required to perform it.
remittance advice (RA)	Explains the payment decisions to the provider.
Resource Based Relative Value System (RBRVS)	Fee calculation that factors several elements into the nationally uniform relative value; the calculation includes a geographic adjustment and conversion factor.
resubmit	To submit an insurance claim a second time.
RVU (relative value unit)	Unit of measurement assigned to the medical service based on the relative skill and time required to perform it.

S

scrubber	An editing software program that analyzes claims and highlights inaccuracies, errors and missing modifiers.
second-party payer	The physician, clinic or hospital.
serving	Process in which a responsible person hand-delivers notice of a court action to the defendant.
sponsor	The service member who has TRICARE.
state compensation laws	Laws that cover employers and employees within each state.
state insurance commissioner	An official who reviews insurance companies and the companies' business habits and policy language to determine if they may operate in that particular state.
subscriber	Also known as the insured, this is the person who prepays the fee for insurance coverage.
superbill	A template of commonly used codes in the specific practice that serves as a communication device between the physician and the medical billing specialist.
suspense (pending)	The claim is in review or the insurance carrier is waiting for additional information.

T

TAC (TRICARE allowable charge)	Charge that providers who participate in TRICARE will accept as the full fee for the services they render.
temporary disability	Injury claims for which the employee is expected to be unable to work for a period of time while he recuperates from his injuries.
TFL (TRICARE for Life)	TRICARE's Medicare-wraparound coverage available to all Medicare-eligible TRICARE beneficiaries, regardless of age or place of residence, provided they have Medicare Parts A and B.
third-party payer	An organization other than the patient (first party) or healthcare provider (second party) involved in the financing of personal healthcare services.
threshold limit	The amount at which the copayment drops.
timely filing guideline	The deadline for filing a claim. Each carrier has its own timely filing guideline.
tracer	A form that enables insurance companies to locate missing claims.
TRICARE	Department of Defense healthcare program that provides healthcare coverage for medical services, medications and dental care for military families, retirees and their families and survivors.
TRICARE allowable charge (TAC)	Charge that providers who participate in TRICARE will accept as the full fee for the services they render.

TRICARE Extra	A PPO-type option that provides healthcare services on a visit-by-visit basis.
TRICARE for Life (TFL)	TRICARE's Medicare-wraparound coverage available to all Medicare-eligible TRICARE beneficiaries, regardless of age or place of residence, provided they have Medicare Parts A and B.
TRICARE Prime	An HMO-type option that is currently the least costly healthcare plan offered through TRICARE.
TRICARE Standard	The fee-for-service option that gives beneficiaries the opportunity to see any TRICARE-authorized provider.

U

UB-04	Also known as the CMS-1450, this is the uniform claim form used in hospitals and other inpatient settings.
UCR (usual, customary and reasonable)	The maximum amount the insurer will consider eligible for reimbursement under a health insurance plan.
usual	Indicates what a typical doctor normally charges for a service.
usual, customary and reasonable (UCR)	The maximum amount the insurer will consider eligible for reimbursement under a health insurance plan.
utilization review	A process intended to ensure that the care a patient receives is medically necessary and delivered in the most appropriate location, and that it follows generally accepted medical standards.

V

veteran	A person who has served in a uniformed service for the United States, who is no longer in the service and who has received an honorable discharge.
visitation limits	Limits on the number of visits to specialists that a patient may make, or the number of special treatments a patient may have.

W

Web-based claim submission	Process by which the biller enters the claim information directly into the insurance carrier's Web site.
weight	The average of the resources necessary to care for cases in a DRG.
workers' compensation	Also known as work comp, this program provides coverage to employees and their dependents if an employee suffers a work-related accident causing injury, illness or death.
write-off amount	Amount the provider cannot bill the patient.