

Glossary of Insurance and Medical Billing Terms

A

Accept Assignment	Provider has agreed to accept the insurance company allowed amount as full payment for the covered services.
Adjudication	The final determination of the issues involving settlement of an insurance claim.
Allowed Amount	The amount of the billed charge the insurance company deems is payable.
AMA	American Medical Association www.ama-assn.org
Ambulatory Care	Any medical care delivered on an outpatient basis.
Ancillary Services	Services including laboratory, radiology, home health and skilled nursing facilities
Assignment of Benefits	The patient or guardian signs the Assignment of Benefits form so that the medical provider will receive the insurance payment directly.
Authorization	Approval from insurance company is required for patient to receive services. Prior Authorization may be necessary before hospital admission, or before care is given by non-HMO providers.

B

Beneficiary	Person covered by health insurance or Medicare benefits.
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C

Capitation	A payment methodology in which the physician is paid a set dollar amount determined by per member per month calculation to deliver medical services to a specified group of people.
CCS	California Children Services -- A state program for children with certain diseases or health problems.
CHDP	Child Health and Disability Prevention Program -- A preventive program that delivers periodic health assessments and services to low income children and youth in California.
Claim Response Report	Palmetto GBA's GPNet Claim Acceptance Response Report. This report is available for download immediately after claims submission. Report includes total claims submitted, accepted or rejected with error messages.
Clearinghouse	A company that, for a fee, electronically receives batches of claims from providers or billing centers and retransmits the data electronically to the designated payers. There is a contractual financial relationship between the clearinghouse and the payer.
CMS	Centers for Medicare & Medicaid Services -- Formally known as HCFA, CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards.
CMS 1450	UB-04 Uniform Bill formally known as UB-92 used for Institutional billing
CMS 1500	The standard claim form used by health plans on which to consider payment to the medical provider
COB	Coordination of Benefits -- The process to determine the obligation of payers when a patient is covered under 2 separate health care plans to avoid duplicate payments for a single service or procedure.
COBRA	Consolidated Omnibus Budget Reconciliation Act -- Health insurance coverage that you can purchase when you are no longer employed, or awaiting coverage from a new insurance plan to begin.
Contractual Adjustment	A part of the charge that the provider or hospital must write off (not charge the patient) because of billing agreements with the insurance company.
Co-Pay	The portion of a claim that a member must pay out-of-pocket.
CPT Code	Current Procedural Terminology -- A 5-digit code used for describing the specific items and services provided in the delivery of health services. Also known as a Procedure Code.

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D

Deductible The amount an insured member must pay before the insurance company begins covering health care costs.

DHS Department of Health Care Services for California www.dhcs.ca.gov

Diagnosis Code ICD-9 code used to describe illness, injury or diseases

DME Durable Medical Equipment

DOS Dates of Service -- The date(s) when a patient was treated.

E

EDI Electronic Data Interchange

EFT Electronic Funds Transfer -- A paperless computerized system enabling funds to be debited, credited, or transferred from the payer.

EIN Employer Identification Number -- Also known as Tax Identification Number (TIN)

EMR Electronic Medical Records -- Medical record in electronic format.

EOB Explanation of Benefits -- Details regarding how your insurance company processed medical insurance claims, explains what portion of a claim was paid to the health care provider and what portion of the payment.

EPSDT Early and Periodic Screening, Diagnosis, and Treatment -- A Medi-Cal program for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This program allows for periodic screening to determine health care needs.

ERA Electronic Remittance Advice -- Electronic file supplied by the payer to outline payment for submitted claims. Also known as an 835 file.

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F

Fee for Service	A method of payment for medical services rendered
Fee Schedule	A list of CPT codes and dollar amounts an insurance company will pay for a particular medical service
Formulary	List of prescription drugs cost of which an insurance company will reimburse, or those that will provided free under a scheme.

G

GPNet	The EDI gateway to Palmetto GBA
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H

HCPCS	Healthcare Common Procedure Coding System -- 5-digit alphanumeric set of procedure codes based on the AMA CPT codes. A standardized medical coding system for describing the specific items and services provided in the delivery of health services. Also known as a Procedure Code.
HIPAA	Health Insurance Portability and Accountability Act. This federal act sets standards for protecting the privacy of your health information.
HL7	Health Level Seven -- A data exchange protocol and interface for medical records and billing software that allows different systems to interoperate.
HMO	Health Maintenance Organization -- An insurance plan that pays for preventative and other medical services provided by a specific group of participating providers.

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I

ICD-9	International Classification of Diseases -- A standard format to describe the illness, injury or diseases by using a three digit code. Also known as a Diagnosis Code.
IPA	Independent Practice Association -- An organization of physicians who are contracted with an HMO plan
IVR	Interactive Voice Response -- Palmetto GBA 24 hour telephone line, obtain Medicare Part B information, such as claim status, last 3 checks issues, and eligibility.

J

Jurisdiction 1	California, Hawaii, Nevada, Guam, American Samoa, Northern Mariana Islands
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M

MAC	Medicare Administrative Contractor
Medical Necessity	A medical procedure or service must be performed only for the treatment of an accident, injury or illness and is not considered experimental, investigational or cosmetic.
Medi-Cal	Medi-Cal is California's Medicaid program. Provides health services for categorically eligible and low-income persons. www.medi-cal.ca.gov .
Medicare	A health insurance program for people age 65 and older, some people with disabilities under age 65, and people with end-stage renal disease (ESRD). www.medicare.gov
Medigap	Insurance provided by carriers to supplement the monies reimbursed by Medicare for medical services. Medigap is meant to fill this gap in reimbursement, so that the Medicare beneficiary is not at risk for the difference.
Modifier	In CPT coding, a two-digit add-on or five-digit number, representing the modifier, placed after the usual procedure code number. The two-digit modifier may be separated by a hyphen.
MSP	Medicare Secondary Payer

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N

N/C Non-Covered Charge -- Procedure is not covered by health plan.

NPI National Identification Number – Standard unique 10-digit identifier assigned to health care providers by CMS. It replaces all previous identifiers.

P

Palmetto GBA Effective September 2, 2008 Palmetto is the Medicare contractor for Jurisdiction 1 Part A/B. www.palmettogba.com/J1B

Participating Provider A physician or other medical provider has agreed to accept a set fee for services provided to members of a specific health plan.

PCP Primary Care Physician -- The doctor you see first for most health problems and may talk with other doctors and health care providers about your care and refer you to them.

POS Point of Service -- An insurance plan that allows a patient to choose doctors and hospitals without having to first get a referral from his/her primary care doctor.

PPO Preferred Provider Organization -- A plan that contracts with independent providers at a discount for services. The physicians in a PPO are paid on a fee-for-service schedule that is discounted, usually about 10% to 20% below normal fees. A patient can use a physician outside of the PPO providers, but he or she will have to bear a bigger portion of the fee.

Procedure Code CPT or HCPC code used to describe the service rendered.

PTAN Provider Transaction Access Number -- Also known as your legacy Medicare number.

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R

RA	Remittance Advice -- Supplied by the payer to outline payment for submitted claims. Also contains explanations for claim denials. Also referred to as EOB.
Referral	Permission from your primary care doctor for you to see a specialist or get certain services.
Responsible Party	The person(s) responsible for paying a patient's office or hospital bill, usually referred to as the guarantor

S

Secondary Insurance	Extra insurance that may pay some charges not paid by the primary insurance company.
Skilled Nursing Facility	Typically an institution for convalescence or a nursing home. The skilled nursing facility provides a high level of specialized care for long-term or acute illness. It is an alternative to extended hospital stays or difficult home care.
SOF	Signature on File
Supplemental Insurance	An additional insurance company that handles claims for deductibles and coinsurance reimbursement. Many private insurance companies sell Supplemental Insurance for Medicare.
Subscriber	For group policies, subscriber is the term used to describe the employee. For individual policies, subscriber is the term to describe the policyholder.

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T

TAR	Treatment Authorization Request -- An authorization number given by insurance companies prior to treatment in order to receive payment for services rendered.
Tele Comm Support	Internet software or hardware support with the staff of Tele Comm Computer Systems, Inc.
Term Date	The date the insurance contract expired or the date a subscriber or dependent ceases to be eligible for coverage.
TIN	Tax Identification Number -- Also known as Employer Identification Number (EIN)
TOS	Type of Service -- A description of the category of the service performed.
TTY	Teletypewriter for the hearing impaired

U

UPIN	Provider Unique Personal Identification Number -- No longer utilized as of May 23, 2008
Untimely Submission	A medical claim must be submitted within the time frame given by the insurance company or the claim will be denied.

X

XPrint	Terminal Emulator that enables printing from the Legacy Medical Billing system
XTerm	Terminal Emulator to connect the Legacy Medical Billing system