National
Family Planning
& Reproductive Health Association

Glossary of Frequently Used Billing and Coding Terms

Accountable Care Organization (ACO)	A group of health care providers who coordinate care and disease management, and thereby improve the quality of care for patients. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.
Accounts Receivable Reports	Reports that show payments billed but not paid by month or quarter and by payer and/or service delivery site.
All Inclusive Fees	Used in some Medicaid programs or other insurance plans where services provided are combined into one bundle for the purpose of payment and providers receive the same payment for each client regardless of the particular services they received. Popular in the past in Medicaid programs, all-inclusive fee structures are disappearing as more programs set fees based on diagnosis, procedure, and the supplies related to treatment.
Allowances and Adjustments	Allowances are an adjustment made to gross charges (see definition) based on the contractual amount a practice is paid by each insurance company for the service or supply that is charged on a bill. Also called a "contractual allowance", the practice of applying allowances to the accounts receivable (see definition) adjusts the amount projected for collection by the service provider so that staff can accurately monitor revenue received compared to adjusted charges. Adjusted charges are also referred to as Net Charges (versus Gross charges).
Capitation Payments	Traditionally used by HMOs and other managed care organizations, capitation payments are monthly payments made by insurers to primary care providers for patients assigned to/enrolled in their care. Rates are set by age, sex and other risk categories by insurance company actuaries or governmental regulators.
Care Coordination (references to Medical Home, Accountable Care Organizations, Health Homes)	The organization of medical treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care. (See also Health Home)

Chargemaster or Charge Description Master (CDM)	A table consisting of all visit types and procedures and items a practice offers/uses. It includes a description of the activity or item, a CPT or HCPCS (see definition) code and a dollar amount that is considered the "charge" for performing that service or providing that supply. Charges included in an organization's chargemaster are developed specifically for that organization based on its cost of operations and service delivery and are not set by any external body. Once developed, they should be compared to the rates paid by all of that agency's payers (Medicare, Medicaid and insurance plans) to ensure that charges are set at or above the highest reimbursement rate paid by the insurers for that service or device. The charge for a service delivered is typically developed by identifying how much staff time is utilized in the typical delivery of that service and the salary & benefit cost of that staff time plus an amount for the use of the facility for that amount of time and an additional percentage for administrative processing of the patient for the visit and the overall administrative costs for operating the site; this can include such costs as depreciation. The charge for a supply item is developed by taking the cost of the item plus an amount for staff time utilized in inserting/removing a device, delivering a drug, etc., and an additional administrative percentage as with services. NOTE: See Charges for additional information on how this is used.
Charges	Once set in a chargemaster, charges are used in the management of the accounts receivable for the service provider. Charges are referred to as Full or Gross charges if they have not been adjusted in any way, and are the top rate billed to any patient or insurer when a fee scale or contract is not in place. If a patient is on a sliding scale, or has insurance that pays a set rate lower than the charge, the accounting staff or system should adjust the Gross charge by the amount reflected in the fee scale or contract; this adjustment is often known as making an "allowance" or "contractual allowance." Once a charge has been adjusted, it is referred to as an "adjusted charge" or "net charge" and that amount becomes the reference point for determining how much should be collected for that service. For example, if a patient's visit gross charge is $200 based on the chargemaster for the CPT/HCPCS codes used in the visit but the patient is on a sliding scale to pay only $50, the charge would be adjusted to $50. Similarly, if an insurance plan contract specifies that the plan will pay $150 for that service, the charge would be adjusted to $150 as a contractual allowance. If the patient then pays $50, her account is considered paid in full based on the adjusted or net charge. If the plan, for some reason, pays $100 instead of $150, there is then an outstanding balance to the plan of $50 which is then addressed by staff responsible for accounts receivable.
Chief Complaint	Concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the patient encounter, usually stated in the patient's own words. Should be clearly reflected in the medical record.
CMS 1500 (Formerly HCFA 1500)	The official standard form used by physicians and other providers when submitting bills/claims for reimbursement to Medicare or Medicaid for health services. It is also used by private insurers and managed care plans. CMS 1500 contains patient demographics, diagnostic codes, CPT/HCPCS codes, diagnosis codes, units, etc. It can be used manually or electronically programmed into a billing system.

Co-equal Diagnoses	When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided. Any one of the diagnoses may be listed first. (See also Primary Diagnosis)
Credentialing for Insurance Plans	Insurance plans require providers to be "credentialed" to their plan, much like hospitals and health centers require providers to have their credentials verified and approved by the Medical Board or similar committee. Credentialing providers to plans requires submission of documents to the plan for review and approval and the approval process often takes several months. Some plans have requirements for providers to have hospital admitting privileges and/or have minimum insurance coverage requirements and will not credential them without compliance with those rules.
Current Procedural Terminology (CPT)	A system developed by the American Medical Association for standardizing the terminology and coding used to describe medical services and procedures. These are used in combination with ICD-9 (see definition) codes to determine payment levels by insurance plans as well as standardizing information about what procedures are done for a patient across different sites.
Days to Bill/Days to Pay Reports	These reports show how long it takes for a bill to leave the facility to go to the insurer after the date of service and how long it takes for payment to be received after the date of service. With many plans requiring timely submission of claims, tracking days to bill is important to ensure that claims are sent out within contract-mandated time frames. Similarly, contracts often include language specifying when the insurer has to make payment after receiving the claim and days to pay reports can be used to track slow-paying plans and attempt to work with them to improve cash flow.
Denial	Claim that is not paid by an insurance carrier. Denials can be made for many reasons: non-credentialed provider, client not insured on date of service, service not covered, prior authorization needed but not on claim, etc. Denials can often be appealed under the terms of the agency's contract.
Denial Management	Categorizing and working on denials by different criteria such as payer type, days since date of service, denial reason, type of service provided. Timely action on denied claims is essential.
Diagnosis Code (Currently called ICD-9. This will change to a new set of codes called ICD-10 in the future [date of change to be determined].)	Alphanumeric codes used to identify diagnoses for the purposes of computer storage. In combination with CPT codes, these are used to determine payment by Medicare, Medicaid Managed Care plans, commercial insurance plans and some Medicaid programs. (See also ICD and CPT)
Electronic Billing	Electronic billing occurs when claims are sent from a provider to an insurer electronically from their practice management system or a billing module within their Electronic Health Record system. Electronic billing addresses significant problems created by paper claims such as eliminating transposed values, lost claim forms, etc.

Evaluation and Management	Describes the medical visit a patient has with clinician; E/M, Medical Visit, Evaluation and Management are terms used inter-changeably.
Explanation of Benefits (EOB)	A letter that goes to an insured person when a claim is filed with the insurance company for services. Primarily created for fraud prevention, EOBs are used consistently by some plans in some states; in other states or companies, the usage varies from random to occasional. EOBs may be a concern for patients receiving confidential services as the EOB is sent to the policy holder, NOT the person receiving the services, so it can breach confidentiality.
Facilitated Enrollment	Enrollment into public insurance plans conducted by staff that have been trained to screen patients for eligibility in various public insurances and to either complete the enrollment for the patient or assist the patient with the enrollment process.
Federally Qualified Health Center (FQHC)	Federally designated and funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of a patient's ability to pay. Services are provided on a sliding scale fee based on patient's ability to pay. Medicaid rates for FQHCs are set federally based on annual cost reports and are generally higher than state-set Medicaid clinic/health center rates. In addition, FQHCs operating in states with Medicaid Managed Care (MMC) plans receive a "wrap around" payment that brings their reimbursement for a MMC client's visit up to their federally set visit rate if the MMC reimburses them below that level. FQHCs participate in the Federal Tort pool, which exempts them from paying local malpractice insurance and results in any malpractice suits being heard in Federal court rather than state or local courts.
Fee for Service	A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits. There are two alternatives to FFS payment: Managed Care Capitation and All Inclusive rates. (See also Managed Care and All Inclusive Fees.)
FQHC Look-Alike	A health center that complies with all requirements to become an FQHC but which does not receive Federal Funding from the Section 330 funding pot reserved for FQHCs. Look-Alikes cannot participate in the Federal Tort pool. Look-Alikes are allowed to purchase prescription drugs and devices at reduced cost through the 340B program and also receive the same enhanced reimbursement rate afforded to FQHCs.
Health Care Common Procedure Coding System (HCPCS)	Standardized identification of medical services, supplies, and equipment. There are two sets of codes. The first, or Level I, code set is a five-digit numeric code that contains the CPT. The second code set, or Level II, is a set for medical services not included in Level I, such as durable medical equipment and supplies. (Often pronounced hickpicks) (See also Current Procedural Terminology [CPT])
Health Care Cooperatives	A non-profit entity in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state or local level, and can include doctors, hospitals and businesses as member-owners.

Health Insurance Exchange (or Exchange)	A competitive insurance marketplace established by the Affordable Care Act (ACA) where individuals and small businesses can buy qualified health benefit plans. Exchanges will offer individuals a choice of health plans that meet certain benefits and cost standards. Under the ACA, states must set up and run their own exchange, request assistance from the Federal government in setting one up, or let the Federal government create and run an exchange for the residents of the state. Insurance plans offered through exchanges may have subsidized premiums for those eligible for subsidy under the ACA.
Health Home	A federally defined term for a care coordination structure for chronically ill Medicare/Medicaid beneficiaries that identifies one of the multiple organizations caring for those individuals as their "health home" and provides reimbursement to that organization for case management services intended to improve the beneficiary's health and reduce costs.
International Statistical Classification of Diseases (ICD-9 or ICD-10)	A coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO). The 10th edition code set (ICD-10) allows more than 14,400 different codes and permits the tracking of many new diagnoses. Using optional sub-classifications, the codes can be expanded to over 16,000 codes. (See also Diagnosis Code)
Managed Care	Any arrangement for health care in which an organization, such as an Health Maintenance Organization (HMO), another type of doctor-hospital network, or an insurance company, acts an intermediate between the person seeking care and the provider.
Modifier	A two-digit code that can be put on a claim next to a CPT code for the purpose of affecting the allowed payment (commonly results in an increased allowed payment). (See also Current Procedural Terminology [CPT])
Navigator	New role defined in the Affordable Care Act; person or entity that is tasked with informing individuals and small employers about the availability of qualified health plans within the Exchange and facilitating enrollment of qualified individuals into such health plans. Since the Exchange will determine eligibility for advanced premium tax credits, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Program as applicable, the role of the Navigator also includes outreach and education efforts, and assistance applying for coverage in such programs.
Patient Type	Definition of patients based on frequency of service. New patient - an individual who has NOT received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous three years; Existing Patient - an individual who has received a service within the last 3 years.
Patient-Centered Care	Health care that establishes a partnership among practitioners, patients, and their families intended to ensure that decisions respect patients' needs and preferences, and that patients have the education and support they need to make decisions and participate in their own care. This is frequently used in the context of the medical home model. (See also Patient-Centered Medical Home)

Patient-Centered Medical Home	A transition away from a model of symptom- and illness-based episodic care to a system of comprehensive coordinated primary care. Personal physicians are responsible for the patient's coordination of care across all health care systems facilitated by registries, information technology, health information exchanges, and other means to ensure patients receive care when and where they need it. With a commitment to continuous quality improvement, care teams utilize evidence-based medicine and clinical decision support tools that guide decision making. Payment appropriately recognizes and incorporates the value of the care teams, non-direct patient care, and quality improvement provided in a patient-centered medical home. (See also Patient-Centered Care)
Payment Reconciliation Reports	Reports that show charges, projected payments, payments received and the variances so that problems can be identified and addressed by looking at the universe of claims rather than individual claims.
Presumptive Eligibility	Option given to states to provide immediate temporary Medicaid coverage to applicants who seem to be eligible for the program. Temporary coverage of services is extended until Medicaid issues a decision on the eligibility of the applicant. A provider would be reimbursed for services even if the patient is later found to be ineligible for coverage under Medicaid.
Primary Diagnosis	Code assigned to the diagnosis, condition, problem, or other reason shown in the documentation to be chiefly responsible for services provided.
Remittance (Paper or electronic)	Information included with the payment from an insurer that describes what services and payments are included in the payment sent to the provider. This tool is used for posting payments to individual patients' accounts and to identify partial payments and denied payments that require provider action.
Revenue Cycle Management	A process of reviewing and monitoring every step of the coding, billing, collection, posting and denial management processes for collecting revenue. It is designed to help organizations see how each step leads to the next step and how monitoring the various steps can help to increase collections.