PMBA

PROFESSIONAL MEDICAL BILLERS ASSOCIATION

"Certifying Excellence in Medical Billing."

Medical Billing Terminology

Medical Billing Terminology

To keep medical insurance in force, a person must pay a monthly, quarterly, or annual fee called a premium. If the premium is not paid, a grace period of 10 to 30 days is usually given before insurance coverage ceases. In addition, usually a deductible (a specific amount of money) must be paid each year before the policy benefits begin. After the deductible is met, the insurance company begins to pay part of the cost usually 80%. The higher the deductible is, the lower the cost of the policy. Most policies have a coinsurance or cost-sharing requirement, which means the insured will assume a percentage of the fee (e.g., 20%) or pay a specific dollar amount (e.g., $15) for covered services. Managed care plans and state and federal programs refer to this as copayment (copay).

It is not advisable to routinely waive copayments because most insurance companies do not tolerate this practice. If the provider is audited, the federal government can assess penalties for not collecting copayments for patients seen under the Medicare program. However, if copayments are waived on a case-by-case basis, as in a courtesy discount, there should not be any problems with commercial insurance carriers or Medicare. Generally, deductibles and copayments should be collected at the time of service.

Coinsurance Example:

Co-insurance refers to the portion of medical costs that is shared between the policyholder (the insured individual) and the insurance company after the deductible has been met. In health insurance, a deductible is the specified amount that the insured person must pay out of pocket before the insurance coverage begins to contribute to the expenses.

Insurance coverage is $10,000

Accepted Coinsurance Policy: 20/80

Insurance agrees to pay $8,000 and patient needs to pay $2,000.

Before his visit, insured person should make sure his doctor was in the plan network* so he could get the most coverage and pay less out of his own pocket. If visits a provider outside his plan network, he may pay more.

Deductible Example:

A typical auto insurance policy, for example, may carry a $400 deductible.

If the owner of that car accidentally hits another car while parking and both drivers agree the damage is minimal, he or she would pay the $400 repair bill out of his or her own pocket.

Insurance companies would not encourage a claim for such minor damages.

The next time, if the accident happens, insurance starts paying as the deductible has been met.

In a similar way, patients who visit the emergency room for a minor injury or procedure would have to pay out of pocket until they have reached the level of the deductible.

If their medical expenses on a visit to the hospital would exceed the deductible, then the insurance company would pay the total charges minus the deductible.

Out-of-Pocket Expenses

An out-of-pocket expense is a non-reimbursable expense paid by a patient. This could include any medical benefits that health plan doesn't consider "covered services." Out of pocket means, the costs borne by the member that are not covered by the healthcare plan.

Medicare: is the largest health insurance payer in the United States. It is a federally funded program legislated by the entity known as CMS (Centers for Medicare and Medicaid Services).
Abuse An act that directly or indirectly results in unnecessary reimbursement without defined intent.

Advanced Beneficiary Notice: The Advanced Beneficiary Notice (ABN) is a report given to Medicare beneficiaries to let the patient know that Medicare is not likely to pay for certain services. The notice must be given to the patient before services are performed. CMS has modified its form and given explicit instructions how the form should be completed. According to regulations, providers include physicians, institutions such as outpatient hospitals, practitioners and suppliers paid under Part B, and hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A. The ABN form must be verbally reviewed with the beneficiary or their representative before they sign it. Once

completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain the original notice on file. These forms are not required in emergency or urgent care situations.

Approved charges: Fee that Medicare decides the medical service is worth, which may or may not be the same as the actual amount billed. The patient may or may not be responsible for the difference.

Assignment: For Medicare, an agreement in which a patient assigns to the physician the right to receive payment from the fiscal intermediary. Under this agreement, the physician must agree to accept the program payment as payment in full except for 20% or the reasonable (allowed or approved) charge and the deductible.

Benefit period: Period of time for which payments for Medicare inpatient hospital benefits are available. A benefit period begins the first day an enrollee is given inpatient hospital care (nursing care or rehabilitation services) by a qualified provider and ends when the enrollee has not been an inpatient for 60 consecutive days. For disability insurance, it is the maximum amount of time that benefits will be paid to the injured or ill person for a disability.

Beneficiary: The term "Medicare beneficiary" refers to an individual who is eligible to receive benefits from the Medicare program. Medicare is a federally funded health insurance program in the United States that primarily provides coverage for individuals who are aged 65 and older, as well as certain younger individuals with specific disabilities or qualifying medical conditions.

Coinsurance: Co-insurance refers to the portion of medical costs that is shared between the policyholder (the insured individual) and the insurance company after the deductible has been met. In health insurance, a deductible is the specified amount that the insured person must pay out of pocket before the insurance coverage begins to contribute to the expenses.

Once the policyholder has paid the deductible amount, co-insurance comes into effect. It is expressed as a percentage, indicating the proportion of the medical costs that the insurance company and the insured individual will share. For example, if the co-insurance is 20%, the insurance company will pay 80% of the eligible medical expenses, while the policyholder will be responsible for paying the remaining 20%.

Here's an example to illustrate how co-insurance works:

Let's say John has a health insurance plan with a $1,000 deductible and a co-insurance rate of 20%. He incurs medical expenses of $5,000 during the coverage period.

Step 1: John pays the $1,000 deductible out of pocket first.

Step 2: After meeting the deductible, the co-insurance kicks in. The insurance company will cover 80% of the remaining $4,000 in medical expenses, which amounts to $3,200.

Step 3: John is responsible for paying the remaining 20% co-insurance, which is $800.

In this scenario, the total amount paid for medical expenses is $1,000 (deductible) + $800 (co-insurance) = $1,800. The insurance company paid $3,200.

Co-insurance helps share the financial burden of healthcare costs between the insured individual and the insurer, making healthcare more affordable and accessible. It is important for policyholders to understand their co-insurance rate and the terms of their health insurance policy to budget and plan for potential out-of-pocket expenses when seeking medical care.

Crossover claim: Bill for services rendered to a patient receiving benefits simultaneously from Medicare and Medicaid. Medicare pays first and then determines the amounts of unmet Medicare deductible and coinsurance to be paid by Medicaid.

Co-payment: A fixed amount paid by the policyholder at the time of receiving medical services, typically for office visits or prescriptions.

Coordination of Benefits (COB): The process of determining which insurance plan is primary and secondary when an individual is covered under multiple insurance policies.

Clearinghouse: An electronic intermediary between healthcare providers and payors that processes and forwards medical claims to insurance companies for payment.

CMS-1500 Form: The standard paper claim form used to submit medical claims for services provided to Medicare and Medicaid beneficiaries.

Deductible: The amount that the policyholder must pay out-of-pocket before the insurance company starts covering medical expenses.

Diagnosis-Related Group (DRG): The DRG abbreviation stands for Diagnosis-Related Group. DRGs are used as a patient classification system to relate the reason a patient was seen in a hospital to the costs incurred by the hospital in the care of the patient. Patients are classified into Diagnostic, Demographic, and Therapeutic groups to analyze resource needs. Hospitals receive money for each case that falls into a specific DRG that is a preset reimbursement amount for that DRG.

Disabled: For purposes of enrollment under Medicare, individuals younger than 65 years of age who have been entitled to disability benefits under the Social Security Act or the railroad retirement system for at least 24 months are considered disabled and are entitled to Medicare.

Effective Date: The date on which an insurance policy or coverage becomes active.

Exclusion: A specific medical condition, treatment, or service that is not covered by an insurance policy.

Explanation of Benefits (EOB): A statement sent by an insurance company to a policyholder, detailing the costs, services, and payments related to a claim.

Fee-for-Service: A payment model in which healthcare providers are paid for each service or procedure they deliver.

Formulary: A list of prescription drugs that are covered by an insurance plan

End-stage renal disease: Individuals who have chronic kidney disease requiring dialysis or kidney transplant are considered to have ESRD. To qualify for Medicare coverage, an individual must be fully or currently insured under Social Security or the railroad retirement system or be the dependent of an insured person. Eligibility for Medicare coverage begins with the third month at the beginning of a course of renal dialysis. Coverage may begin sooner if the patient participates in a self-care dialysis training program or receives a kidney transplant without dialysis.

Fiscal intermediary (FI): An organization under contract to the government that handles claims under Medicare part a from hospitals, skilled nursing facilities, and home health agencies. Also known as fiscal agent, fiscal carrier, and claims processor.

Fraud: Intentional deception made for personal gain. Fraud is a crime, and a civil law violation.

Health Care Financing Administration (HCFA): Health Care Financing Administration, (pronounced "HICK-fah"). The preferred term is now Centers for Medicare & Medicaid Services (CMS), an agency of the US Dept. of HHS that administers Medicare, the federal part of Medicaid and oversees Medicare's health financing; HCFA establishes standards for medical providers that require compliance to meet certification requirements.

Hospice: A public agency or private organization primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill patients and their families.
Health Maintenance Organization (HMO): A type of managed care organization that provides healthcare services through a network of doctors, hospitals, and other healthcare providers.

Hospital insurance: Known as Medicare Part A. A program providing basic protection against the costs of hospital and related post-hospital services for individuals eligible under the Medicare program.

Intermediate care facilities (ICFs): Institutions furnishing health-related care and services to individuals who do not require the degree of care provided by hospitals or nursing facilities.

In-network Provider: A healthcare provider who has a contract with an insurance company to provide services at negotiated rates to policyholders.

Limiting charge: A percentage limit on fees, specified by the legislation, that nonparticipating physicians may bill Medicare beneficiaries above the fee schedule amount.

Medical necessity: Criteria used by insurance companies when making decisions to limit or deny payment in which medical services or procedures must be justified by the patient's symptoms and diagnosis.

Medicare: A nationwide health insurance program for persons aged 65 years and older and certain disabled or blind persons regardless of income, administered by CMS. Local Social Security offices take applications and supply information about the program.

Medicare/Medicaid (Medi-Medi): Refers to an individual who receives medical and/or disability benefits from both Medicare and Medicaid programs. Sometimes referred to as a Medi-Medi case.

Medicare secondary payer (MSP): Primary insurance plan of a Medicare beneficiary that must pay for any medical care or services first before Medicare is sent a claim.

Medicare summary notice: Document received by the patient explaining amount charged, Medicare approved, deductible, and coinsurance for medical services rendered.

Medical Necessity: The criteria that must be met for a healthcare service or treatment to be covered by an insurance plan

Medigap: A specialized insurance policy device for the Medicare beneficiary that covers the deductible and copayment amounts typically not covered under the main Medicare policy written by a nongovernmental third-party payer. Also known as Medifill.

National provider identifier (NPI): A Medicare lifetime 10-digit number issued to providers.

Nonparticipating physician (Nonpar): A provider who does not have a signed agreement with Medicare and has an option regarding assignment. The physician may not accept assignment for all services or has the option of accepting assignment for some services and collecting fees from the patient for other services performed at the same time and place.

Original Medicare: Original Medicare is fee-for-service coverage under which the government pays health care providers directly for a patient's Part A and/or Part B benefits.

Out-of-network Provider: A healthcare provider who does not have a contract with an insurance company and may result in higher outof-pocket costs for the policyholder.

Nursing facility: A specially qualified facility that has the staff and equipment to provide skilled nursing care and related services for patients who need medical or nursing care or rehabilitation services. Formerly known as skilled nursing facility.

Participating physician (Par): A physician who contracts with an HMO or other insurance company to provide services. A physician who has agreed to accept a plans payment for services to subscribers (e.g., some Blue plans). 80% of practicing American physicians are participating physicians.

Peer review organization (PRO): A group of practicing physicians paid by the federal government to review hospital care of Medicare patients regarding effectiveness and efficiency.

Premium: A monthly fee that enrollees pay for Medicare part B medical insurance. This fee is updated annually to reflect changes in program costs.

Pre-authorization: The process of obtaining approval from an insurance company before receiving certain medical services or treatments.

Prospective payment system (PPS): A method of payment for Medicare hospital insurance based on DRGs (a fixed dollar amount for a principal diagnosis).

Qui tam action: An action to recover a penalty, brought by an informer in a situation in which one portion of the recovery goes to the informer and the other portion to the state or government.

Reasonable fee: A charge is considered reasonable if it is deemed acceptable after peer review even though it does not meet the customary or prevailing criteria. This would include unusual circumstances or complications requiring additional time, skill, or experience in connection with a particular service or procedure.

Relative value unit (RVU): Individual building block of RBRVS (resource-based relative value scale). For each service, there are three RVUs: for work, practice expenses, and the cost of professional liability insurance.

Remittance advice (RA): An explanation of services periodically issued to recipients or providers on whose behalf claims have been paid by the Medicare or Medicaid program. Also known in some programs as an Explanation of Benefits (EOB).

Resource-based relative value scale (RBRVS): A system that ranks physician services by units; a Medicare fee schedule.

Respite care: Short-term hospice inpatient stay that may be necessary to give temporary relief to the person regularly assist with the care of the patient.

Supplemental Security Income (SSI): A program of income support for low-income aged, blind, and disabled persons established by Title XVI of the Social Security Act.

Supplementary Medical Insurance (SMI):

Part B - medical benefits of Medicare program.

Volume performance standard Desired growth rate for spending on Medicare Part B physician services, set each year by Congress.

Third-Party Administrator (TPA): An organization that manages claims and administrative services on behalf of self-insured employers or insurance companies.

Underwriting: The process of evaluating an individual's risk profile to determine their eligibility for insurance coverage and the associated premium rates.

Workers' compensation (WC) insurance: A contract that ensures a person against on-the-job injury or illness. The employer pays the premium for his or her employees.

Utilization Review: The process of evaluating the necessity, appropriateness, and efficiency of medical services.

UB-04 Form: The standard claim form used by hospitals and healthcare facilities to bill for inpatient and outpatient services.

Disclaimer

The information provided in this article is for general informational purposes only and should not be construed as professional/legal advice. Readers are encouraged to seek individualized guidance from qualified professionals in the relevant field. The author and PMBA are not liable for any actions taken based on the information presented in this article. All views expressed are solely those of the author and do not necessarily reflect the views of the website.

July 2023