REVENUE CYCLE MANAGEMENT

Contents

1. GLOSSARY

American Medical Association (AMA)

The largest consortium of doctors in the US. Their publication: American Medical Association is a widely distributed medical journal in the world.

Adjustment

The portion of medical bill that doctor or hospital has agreed not to charge Patient.

Aging

Any claims or unpaid insurance that are due past 30 days.

Appeal

A process by which a doctor or the Patient can object to payer when they disagree with the health plan's decision not to pay for care provided.

Accounts Receivables (AR)

A term used to indicate outstanding amount of money that the hospital or physician are still hoping to get paid for.

Assignment of Benefits

Insurance payments which are sent directly to the patient's doctor or hospital.

Authorization

Approval of care required before a service is provided. Pre-authorization may be necessary before hospital admission, or before care is given by non-HMO providers.

Beneficiary

Person or persons covered by the health insurance plan.

Bill/Invoice/Statement

Printed summary of patients' medical bill.

Billing

The procedure by which medical bills are collected from insurance companies within hospitals or other healthcare facilities.

Blue Cross and Blue Shield Association (BSBSA)

An association which represents the common interests of Blue Cross and Blue Shield health plans. The BCBSA serves as the administrator for the Health Care Code Maintenance Committee and also helps maintain the HCPCS Level II codes.

Claim

A request by a patient (or his or her provider) to that individual's insurance company to pay for services obtained from a healthcare professional, or an itemized statement of healthcare services and their costs provided by a hospital, physician's office, or other provider facility. Claims are submitted to the insurer by either the patient or the provider for payment of the costs incurred.

Claim Denial

The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for healthcare services.

Co-payment

Fixed amount owed for a healthcare service, due at the time the services are provided. Technically a form of coinsurance, the copay must be paid before any policy benefits are payable by an insurance company.

Capitation

A fixed payment paid per patient enrolled over a defined period of time, paid to a health plan or provider. This covers the costs associated with the patient's health care services.

CHAMPUS

Civilian Health and Medical Program of the Uniformed Services. Now known as TRICARE. A federal health insurance for military personnel, National Guard, retirees, their families, and survivors.

Charity Care

Medical care provided at no cost or at low cost to patients who cannot afford it.

Clean Claim

A term used for a complete submitted insurance claim that has all the necessary correct information without any omissions or mistakes that allows it to be processed and paid promptly.

Clearinghouse

it is a service that checks insurance claims for errors. It helps in minimizing rejected claims by timely correcting the errors. Clearinghouse electronically transmits HIPAA complaint claims to insurance carriers.

Center for Medicaid and Medicare Services (CMS)

A Federal agency that governs HIPPA, Medicare, Medicaid and other health programs.

Co-insurance

The cost sharing part of the bill that patient have to pay. For Medicare, the percent of the approved charge that patient have to pay either after patient pay the Part A deductible, or after pay the first $100 deductible each year for Part B.1

Coding

It involves taking the doctors notes from a patient visit and translating them into the proper ICD-10 code for diagnosis and CPT codes for treatment.

Deductible

The amount owed by the patient for healthcare services before the plan begins to pay. Depending on the plan, some services may be covered before the deducible is met, and after many plans require patients to share in the cost via coinsurance.

Date of Service (DOS)

The date(s) when patients were treated.

Day Sheet

A sum up of treatments provided and daily charges or payments made by the patient.

Demographics

Physical attributes of a patient that are necessary to fill in a claim. Such as age, sex, height or weight.

Denied claim

Insurance claims submitted to an insurance company in which payment has been rejected due to technical error or because of medical coverage policy issues.

Diagnosis Code

A code used for billing that describes your illness.

Durable Medical Equipment (DME)

Medical equipments such as wheelchairs, oxygen, stretchers, glucose monitors, crutches, etc.

Down-coding

if a claim is submitted by the provider without supporting documents, the insurance company will reduce the code to the closest matching code thereby reducing the payment.

Electronic Claim

Insurance claim submitted electronically

Electronic Funds Transfer (EFT)

An electronic method of transmitting money. A paperless system of debiting or crediting money into an account.

Electronic Medical Record (EMR)

The electronic record of health-related information on an individual that is created, gathered, managed, and consulted by licensed clinicians and staff from a single organization who are involved in the individual's health and care

Explanation of Benefits (EOB)

A statement describing medical benefits and account activity, including explanation of why certain claims may or may not have been paid.

Electronic Remittance Advice (ERA)

This is an electronic version of EOB. It gives details of insurance claim payments and is designed to comply with HIPAA standards.

Fee Schedule

A listing of the maximum fee which a health plan will pay for services based on CPT billing codes.

Financial Responsibility

Charges that the patient or the insurance holder is liable to pay.

Fee-for-Service

A method in which doctors and other healthcare providers are paid for each service performed. Examples of services include tests and office visits.

Financial Policy

Written policy developed by a healthcare organization that outlines its revenue cycle management process and sets expectations for patients about their financial responsibility for services rendered. This should be clear and concise, and reviewed with every patient before providing care.

Group Name

Name of the insurance plan or group that the patient is insured under.

Guarantor

Someone who has agreed to pay the bill.

Healthcare Revenue Cycle

All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.

Healthcare Common Procedure Coding System (HCPCS)

A medical code set, which has been selected for use in the HIPAA transactions, identifies health care procedures, equipment, and supplies for claim submission purposes. HCPCS Level I contain numeric CPT codes which are maintained by the AMA. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. These are maintained by HCFA, the BCBSA, and the HIAA. HCPCS Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in levels I or II.

Health Insurance Portability and Accountability Act (HIPAA)

This act, which was passed in 1996, helps ensure that privacy is maintained in regards to patients' medical records. It also created a set of standards to which all electronic medical records must adhere.

Health Maintenance Organization (HMO)

An insurance plan that pays for preventative and other medical services provided by a specific group of participating providers.

In-Network (or Participating)

A type of insurance plan where the provider signs a contract to become a part of the network.

Inpatient (IP)

Patients who stay overnight in the hospital.

Independent Practice Association (IPA)

An association for physicians that are contracted with a HMO plan.

ICD-10 Code

The Internal Classification of Diseases, 10th Edition, is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care.

Insurance Eligibility Verification

Real-time verification of a patient's insurance coverage and benefits from private or government payers.

Medical Administrative Contractor (MAC)

A company that handles Medicare claims and are contracted to do so by the federal government.

Managed Care Organizations (MCOs)

Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. May apply to EPO, HMO, PPO, integrated delivery system, or other weird arrangement, MCOs are usually prepaid group plans, and physicians are typically paid by the capitation method.

Managed Care Plans

An insurance plan that requires patients to see doctors and hospitals that have a contract with the managed care company, except in the case of medical emergencies or urgently needed care if you are out of the plan's service area.

Maximum Out-of-Pocket

The maximum money you are expected to pay for covered expenses. Once the maximum out-of-pocket has been met, many health plans pay 100% of certain covered expenses.

Medicaid

An insurance program provided by the US government, providing coverage for low income families or other eligible people.

Medical Billing Specialist

They Processes insurance claims for payment of services performed by a physician or other health care provider. Ensures patient medical billing codes, diagnosis, and insurance information are entered correctly and submitted to insurance payer. Enters insurance payment information and processes patient statements and payments. Performs tasks vital to the financial operation of a practice.

Medical Coder

Analyzes patient charts and assigns the appropriate code. These codes are derived from ICD-9 codes (soon to be ICD-10) and corresponding CPT treatment codes and any related CPT modifiers.

Medical Necessity

Any medical procedure that is not investigational, cosmetic, or experimental in nature but done to treat an illness or injury.

Medical Record Number

A unique number assigned to every patient by the healthcare provider to identify the patient medical record.

Non-Covered Charge (N/C)

Any medical service that a patient's insurance plan does not cover.

Network Provider

When a healthcare provider is contracted with an insurer to provide service at a discounted price.

Nonparticipation

A term used to define the procedure when a healthcare provider rejects Medicare approved payment.

National Provider Identifier (NPI)

A unique 10 digit identification number issued by CMS to healthcare providers. This is a HIPAA requirement and assigned through the National Plan and Provider Enumeration System (NPPES).

Out-of Network (or Non-Participating)

A healthcare provider who is not in contract with an insurance carrier. Patients who use an out-of network provider are usually responsible for a greater portion of the charges incurred for the service.

Outpatient Service

A service you receive in one day at a hospital or clinic without staying overnight.

Out-of-Pocket Costs

Expenses for medical care that are not reimbursed by insurance. These costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered.

Practice Management Software

Software used in a healthcare provider's office for appointment scheduling and billing purposes.

Pre-Certification

Sometimes insurer will ask for documentation to determine the medical necessity for the services proposed or given to the patient. It does not necessarily mean that benefits will be paid.

Premium

A monthly charge paid by the insured or their employer to the insurance company.

Primary Care Physician

A physician, usually a general, family practitioner or internist, who delivers general health care, and is most often the first doctor a patient sees. This physician treats the patient directly, refers them to a specialist (or secondary care physician) or admits them to the hospital.

Provider Transaction Access Number (PTAN)

A PTAN is a Medicare-only number issued to providers by Medicare Administrative Contractors (MACs) upon enrollment to Medicare. MAC s issue an approval/notification letter, including PTAN information, when an enrollment is approved.

Patient Account

Detailed record of patient demographic information, medical histories, and insurance coverage. An account is the means of tracking a patient's entire episode of care through the healthcare revenue cycle.

Patient Responsibility

The out-of-pocket costs not covered by a third-party payer, or the amount owed by the patient for services not covered by their insurance plan. This is the amount of the bill the patient is responsible for after insurance determination has been made. (See also: Self Pay)

Payer Mix

The percentage of revenue coming from private insurance vs. government insurance vs. self pay.

Referral

When the primary physician refers a patient to another doctor or a specialist.

Remittance Advice (R/A)

A document submitted by the insurance company with information on claims. This advice gives explanations for rejected or denied claims. Also referred to as Explanation of Benefits.

Responsible Party

A person, group or company responsible for paying a patient's medical bill. Also referred to as the guarantor.

Revenue Code

A billing code used to name a specific room, service (X-ray, laboratory), or billing sum.

Relative Value Amount (RVU)

An average amount that Medicare pays a provider for a treatment. This amount is determined by factors such as: the national uniform value of the service and the geographical location.

Scrubbing

The insurance claim software used to check errors in an insurance claim before submitting it to the payer.

Secondary Insurance

Extra insurance that may pay some charges not paid by the patient's primary insurance company. Whether payment is made depends on his/her insurance benefits, the coverage and the benefit coordination.

Self Pay

Balances due from patients for healthcare services as a result of having no insurance, or having a balance due even after insurance pays due to coinsurance, deductibles, or uncovered services.

Self-Referral

When a patient sees a specialist without a referral made by the primary doctor.

Statement

An invoice that gives details of the service received by the patient.

Treatment Authorization Request (TAR)

An authorization number issued by insurance companies before the treatment is provided to the patient in order to receive payment.

Taxonomy Code

These are codes used to indicate a provider's field of specialty, at times required to process a claim.

Term Date

Date the insurance contract is due to expire.

Third Party Administrator (TPA)

A person or an independent entity who manages benefits, claims and administration for a self-insured company or group.

Tax Identification Number (TIN)

Tax Identification Number. Also referred to as Employer Identification Number (EIN).

TRICARE

This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors. Formerly known as CHAMPUS.

UB-04 Form

A form used by hospitals to file insurance claims for medical services.

Unbundling

Submitting multiple CPT codes when only one is required.

Untimely Submission

When the insurance payer allows a medical claim to be submitted within the time period but any claims submitted after this date are denied.

Upcoding

An illegal practice of assigning an ICD-9 diagnosis code that does not agree with the patient records for the purpose of increasing the reimbursement from the insurance payor.

Unique Physician Identification Number (UPIN)

A 6-digit doctor identification number created by CMS. Now replaced by NPI number.

Value-Based Payment

Strategy used to promote quality and value of healthcare services. The goal of any VBP program is to shift from pure volumebased payment, as exemplified by fee-for-service payments, to payments that are more closely related to outcomes.

V-Codes

ICD-9-CM coding cataloging to recognize health care for reasons other than injury or illness.

Workers Comp

Insurance claim that is a result of a work related injury or illness.

Write-off

A difference between the physician fees and the insurance plan coverage for which the patient is not liable. In other words can be called ‘not covered’.

2. ABBREVIATIONS

Medical Billing and Coding Abbreviations Lists	Expansions
ABN	Advance Beneficiary Notice
ACA	Affordable Care Act
AMA	American Medical Association
AOB	Assignment of Benefits
BIL	Bodily Injury Liability
CDM	Charges Description Master
CF	Conversion Factor
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program for the Veteran Administration
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid
COB	Co-Ordination of Benefits
COBRA	Consolidation Omnibus Budget Reconciliation Act
CPT	Current procedural Terminology
DCN	Document Control Number
DEERS	Defense Enrollment Eligibility Reporting System
DME	Durable Medical Equipment
DOB	Date of Birth
DOI	Date of Injury
DOS	Date of Service
DRG	Diagnosis Related Group
DX	Diagnosis Code
E & M	Evaluation and Management Services
E Codes	External Codes
EAP	Employee Assistance Program
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EGHP	Employer Group Health Plan
E.H.R	Electronic Health Record
EIN	Employer Identification Number
EMR	Electronic Medical Records

EOB	Explanation of benefits
EOMB	Explantion of Medicare Benefits
EPO	Exclusive Provider Organization
ERA	Electronic Remittance Advice
ERISA	Employee Retirement Income Security Act
ESRD	End Stage Renal Disease
FFS	Fee For Service
FI	Fiscal Intermediary
FICA	Federal Insurance Contributions Act
FIR	First Injury Report
FSA	Flexible Spending Account
HCFA	Health Care Financing Administration
HCPCS	Healthcare Common Procedure Coding System
HCRA	Health Care Reform Act
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
ICD	International Classification of Diseases
ICN	Internal Control Number
IME	Independent Medical Examination
IPA	Independent Practice Association
MCP	Managed Care Plans
MHC	Managed Health Care
MRN	Medical Record Number
MSA	Medical Savings Account
MSP	Medicare as a Secondary Payer
MSP	Medicare as a Secondary Payer
MVA	Motor Vehicle Accident
NCPDP	National Council of Prescriptions Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OOA	Out of Area
OON	Out of Network
OP	Out Patient
P-Auth	Pre Authorization
PCN	Primary Care Network

PCP	Primary Care Physician
PDL	Property Damage Liability
PHI	Protect Health Information
PIN	Provider Identification Number
PIP	Personal Injury Protection
POS	Place of service
POS	Point of Service
PPO	Preferred Provider Organization
PTAN	Provider Transaction Access Number
PTFL	Past Timely Filing Limit
PX	Procedure Code
QMB	Qualified Medicare Beneficiaries
RA	Remittance Advice
RBRVS	The Resource Based Relative Value Scale
RCM	Revenue Cycle Management
ROI	Release of Information
RVU	Relating Value Unit
SNF	Skilled Nursing Facility
SOF	Signature On File
SSN	Social Security Number
TAR	Treatment Authorization Request
TC	Technical Component
TCN	Transaction Control Number
TFL	Timely Filing Limit
TIN	Tax Identification Number
TOS	Type of Service
TPA	Third Party Administrators
UB-92/UB-04	Uniform Billing 92/04
UCR	Usual, customary and reasonable
UPIN	Unique Physician Identification Number
UR	Utilization Review
V codes	Vaccination Codes
WC	Worker Compensation
WO	Write Off
ZIP	Zonal Improvement Plan

3. What is the difference between UB-04 and HCFA-1500?

The CMS-1450 is based on the CMS-1500. The UB-04 replaced the UB-92 back in 2007. Because of the complexities of hospital billing, the UB-04 has over twice as many field or blocks for all the different codes and services.

The CMS-1500 form is the health insurance claim form used for submitting physician and professional claims for providers.

When a physician has a private practice but performs services at an institutional facility such as a hospital or outpatient facility, the CMS-1500 form would be used to bill for their services.

The CMS-1450 (UB-04) form is the claim form for institutional facilities such as hospitals or outpatient facilities. This would include things like surgery, radiology, laboratory, or other facility services. Durable Medical Equipment (DME) would typically be submitted using the CMS-1500.

The CMS-1500 is used to submit charges covered under Medicare Part B. The UB-04 or CMS-1450 to submit charges under Medicare Part A.

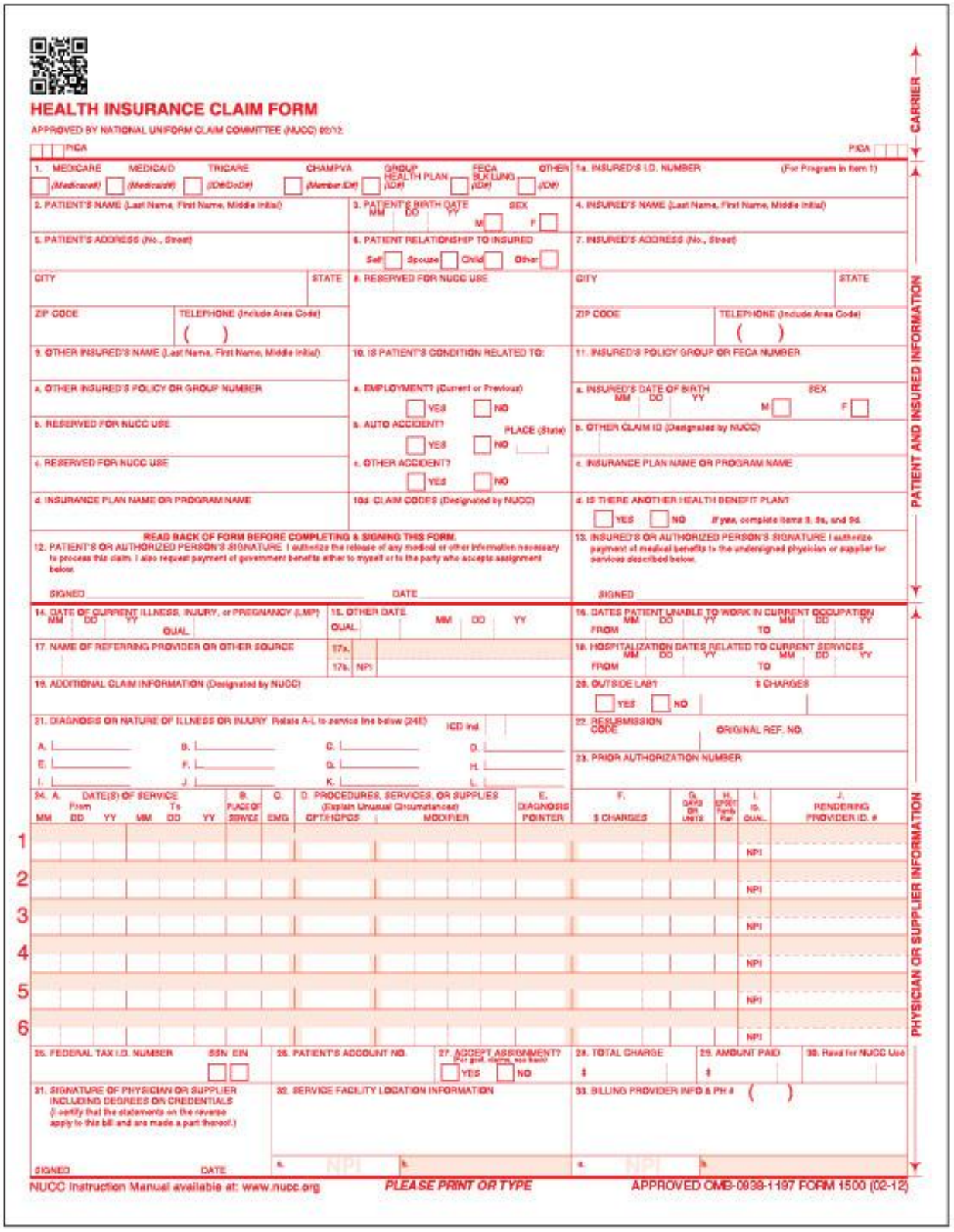
The Centers for Medicare and Medicaid Services is the government entity which mandates use of these forms.

The CMS 1500 claim form is currently the only accepted form for submitting paper claims to both government and commercial health insurance carriers. It is printed in red ink The only forms accepted are the "official" forms printed in Flint OCR Red (J6983) ink.

There are lots of copies of the form available for download, but these cannot be used for submission because the red ink cannot be accurately reproduced. Most claims sent to insurance carriers are scanned using an optical character recognition scanner. This converts the information on the form into electronic format for processing by the carrier.

The CMS 1500 claim form (dated 08-05) replaced the outdated HCFA 1500 health insurance claim form (dated 12-90). One of the biggest changes for the CMS 1500 is the addition of the NPI field. There are several vendors who sell the CMS-1500 claim form in various configurations such as single sheet or continuous feed.

CMS-1500 Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION