

Medical Billing Terminology

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American Medical Billing Association (AMBA)

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And the next Generation:

Felicia Bradford, one of my students. I am very proud of her.

Charlene Hargrove. She has the attributes of someone very experienced. She is a fighter and doesn't take things at face value. The torch has been passed onto her and her generation of coders and billers. Through her the work of our founders will carry on with honor, pride, and professionalism

In Medical Billing, we have our own language. Things such as EOBs, PPOs, HMOs, POSs, Catastrophic Cap, Deductibles and more can be very frightening if not understood. During training, medical coders and medical billers learn medical terminology. Medical Billing terminology is going to the next step to learn language medical billers face every day when interacting with patients, health benefits, and claims. There is a huge difference between otitis media and coordination of benefits (COB). Otitis Media is medical terminology. It is also a diagnosis that is converted by a coder from words to numbers that are recognized by an insurance company. COB is medical billing terminology, used by medical billers when interacting with multiple insurance policies carried by a patient.

ABN (Advanced Beneficiary Notice).

An ABN is a written notice from Medicare (standard government form CMS-R-131), given to you before receiving certain items or services, notifying the patient:

- Medicare may deny payment for that specific procedure or treatment.
- The patient will be personally responsible for full payment if Medicare denies payment.

An ABN gives the patient the opportunity to accept or refuse the items or services and protects the patient from unexpected financial liability in cases where Medicare denies payment. It also offers the patient the right to appeal Medicare's decision. You follow office policy on keeping the ABN form on file and you add the modifier GA to the claim. Modifier GA informs Medicare of the ABN transaction. If you do not have the patient sign the ABN form and the claim is denied, then you cannot bill the patient for the denied claim.

The patient has the option to receive the items or services or to refuse them. In either case, the patient should choose one option on the form by checking the box provided, and then signing and dating it in the space provided.

When the patient signs an ABN and becomes liable for payment, the patient will have to pay for the item or service themselves, either out-of-pocket or by some other insurance coverage which they may have in addition to Medicare. Medicare fee schedule amounts and balance billing limits do not apply. The amount of the bill is a matter between the patient and provider. If this is a concern for the patient, they might want to ask for a cost estimate before they sign the ABN.

Abuse:

Abuse involves charging for services that are not medically necessary, do not conform to professionally recognized standards, or are unfairly priced. An example would be performing a laboratory test on large numbers of patients when only a few should have it. Abuse may be similar to fraud except that it is not possible to establish that the abusive acts were done with an intent to deceive the insurer.

Examples of abuse are:

- Over-utilization of medical and health care services

- Improper billing practices
- Increasing charges to Medicare beneficiaries, but not to other patients
- Routine waiver of deductibles and co-insurance
- Not adjusting accounts when errors are found

Accord and Satisfaction

An accord and satisfaction is a legal term we face when an insurance company or patient writes “paid in full” on the check which is also known as an instrument. Some people do this in the belief that if they do this, they no longer owe anything on their debt. An accord is an offer to settle the debt for an amount that is less than what is owed. A satisfaction is an agreement to the accord. Some states have laws that regulate an accord and satisfaction. For example, under Florida Law, the law states the following:

673.3111 Accord and satisfaction by use of instrument.--

(1) If a person against whom a claim is asserted proves that that person in good faith tendered an instrument to the claimant as full satisfaction of the claim, that the amount of the claim was unliquidated or subject to a bona fide dispute, and that the claimant obtained payment of the instrument, the following subsections apply.

(2) Unless subsection (3) applies, the claim is discharged if the person against whom the claim is asserted proves that the instrument or an accompanying written communication contained a conspicuous statement to the effect that the instrument was tendered as full satisfaction of the claim.

(3) Subject to subsection (4), a claim is not discharged under subsection (2) if either paragraph (a) or paragraph (b) applies:

(a) The claimant, if an organization, proves that:

1. Within a reasonable time before the tender, the claimant sent a conspicuous statement to the person against whom the claim is asserted that communications concerning disputed debts, including an instrument tendered as full satisfaction of a debt, are to be sent to a designated person, office, or place; and

2. *The instrument or accompanying communication was not received by that designated person, office, or place.*

(b) The claimant, whether or not an organization, proves that, within 90 days after payment of the instrument, the claimant tendered repayment of the amount of the instrument to the person against whom the claim is asserted. This paragraph does not apply if the claimant is an organization that sent a statement complying with subparagraph (a)1.

(4) A claim is discharged if the person against whom the claim is asserted proves that within a reasonable time before collection of the instrument was initiated, the claimant, or an agent of the claimant having direct responsibility with respect to the disputed obligation, knew that the instrument was tendered in full satisfaction of the claim.

Now, why is it important for you to know this, it allows you to understand what to do when you get a check with Paid In Full written on it and you see that the patient still has a balance due. For example, Mr. Jones has a debt with the doctor for \$350.00. He sends you a check for \$1.00 and on the check, he writes "Paid In Full." If you knowingly accept the check, then Mr. Jones settled his bill for \$1.00. You can return the check to Mr. Jones declining his offer to settle his debt for \$1.00.

Allowed or Allowable:

This is an amount established by an insurance company that it will pay for a health benefit. This varies per insurance company and per patient benefit contract. Some insurance companies may allow 100% of the submitted charges as the allowable amount. Some may establish their own internal amount. Medicare and Medicaid have their own established allowed amounts. Medicare pays 80% of its allowed amount if the patient has met their annual deductible. The patient pays the other 20% of the allowable. With Medicaid, it pays 100% of its allowable if the service is covered. Doctors or providers, when enrolling with Medicare and Medicaid agree to accept the allowed amount as payment in full. This means the patient cannot be billed for the difference between the provider's charges and the Medicare/Medicaid allowed amounts. For example, a doctor may charge \$160 for an office visit. The patient may have Medicare. Medicare may allow \$60 for the visit. If the patient met their annual deductible, Medicare pays the doctor 80% of

the \$60 or \$48. The patient pays the \$12 difference between the \$60 allowed amount and the \$48 payment. The doctor cannot charge the patient the difference between the \$160 charge and the \$60 allowed amount. The provider must perform an adjustment between the \$160 charge and \$60 allowed amount. The patient can only be billed for their 20% of the allowable and any amounts applied to their deductible. With commercial insurance, if the doctor is non-par or not contracted with the patient's health insurance company, the doctor doesn't have to accept the allowed amount or paid amount as payment in full. The provider can bill the patient the difference between the charges and payment. This may not be so with HMOs in a state with a no-balance billing HMO law.

Ancillary Services:

Medical care, other than those provided by the physician or hospital, which are related to a patient's care. Examples are laboratory work, x-rays, physical therapy, and anesthesia

ATD (Applied to Deductible)

The portion of the claim that the patient is required to meet before the insurance company pays the claim. The claim may have been \$100. The insurance company allows \$100. The patient has a \$100 deductible they haven't met. The EOB is received without payment with the \$100 ATD (Applied to the deductible). You would change the account responsibility to self Pay and bill the patient the \$100 that is owed.

AWP: (Any Willing Provider) Laws:

State Laws that require health insurance companies to accept into their PPO and HMO networks any provider willing to agree to the insurance companies terms and conditions. Also known as Freedom of Choice Laws. Insurance Companies have gone to court to protect their choice not to contract with providers, however, the U.S. Supreme Court has found in favor of the State AWP Laws.

AOB: Assignment of Benefit:


Assignment of Benefit. This is a simple term that can have very drastic consequences. Assignment means to take something and give it to someone else. Example. I assign my parking spot to Jim. I give my parking spot to Jim. Benefit

is a healthcare service provided under a contract between a health insurance company and an employer or patient. SO, an assignment of benefit simply means the patient is asking permission to take the payment of their health benefit and give it to the doctor so that the doctor can apply the benefit payment to the medical debt owed by the patient. Not every patient has the contracted right to assign their benefit payment. Even if you have the patient sign an AOB form, the insurance company doesn't have to honor it if the patient cannot contractually assign their benefit payment to anyone. The only exception is if there is a State Law mandating it. Florida is a State that mandates an insurance company honor an AOB but for emergency care only.

Assignment:

This is a process where an insurance company pays the patient's health benefit directly to the person designated by the patient to receive the payment of the health benefit. The provider has checked "Yes" for "Assignment" on the claim form. The provider has the option to do this on a claim by claim basis. If the provider does NOT accept assignment, the payment of the health benefit is sent to the patient or member. Some insurance companies such as Medicare, Railroad Medicare, and Tricare allow you to bill the patient for 115% of the allowable. For example, if the allowable is \$100, you can bill the patient for \$115.00. Assignment only works if the patient's contract allows the assignment of the benefit payment or State Law mandates acceptance of Assignment.

Block 27 (Assignment) of the CMS 1500 looks as follows.



27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)

<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
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The CMS 1500 instruction form can be found here:

http://www.nucc.org/index.php?option=com_content&task=view&id=33&Itemid=42

Assignment of Benefit (AOB)

This is a request sent to the insurance company, signed by the patient or member, requesting that the payment of their health benefit be sent to a person they designate to receive the payment of the health benefit. This request may or may not be honored and accepted by the insurance company depending on the patient's or member's health benefit contract or State Law. The patient or member's health

benefit contract may prohibit the assignment of the health benefit payment to anyone. State Law such as in Florida and Louisiana may require the insurance company to honor the Assignment request even if the contract prohibits it. If the Assignment is prohibited, the payment of the health benefit will be sent to the patient or member. The requires the provider to bill the patient or member. State Assignment of Benefit Laws can be referenced on the American College of Emergency Physician (ACEP) website:

<http://www.acep.org/advocacy.aspx?LinkIdentifier=id&id=29364&fid=1018&Mo=No>

Authorization:

Some patients, such as HMO patients may be required to obtain permission or authorization to receive certain services. Sometimes this is inpatient medical care which is when the patient is admitted to the hospital by their primary care provider or an emergency care provider or outpatient visits to an out of network provider.

Balance Bill:

This would be the amount of the debt that the patient owes the doctor after the patient's commercial insurance company didn't pay and is being billed for. Balance Billing can be regulated based on the type of health insurance such as Workers Compensation or Medicaid , State law or a provider contract. For example. If the patient has Medicaid and the provider is enrolled with Medicaid, the provider has agreed to accept the Medicaid payment as payment in full. California, Florida and other States have Laws prohibiting the balance billing of an HMO member if the insurance company accepts liability for the claim. In Florida, this law would be FS 641.3154. The contract that the provider has, may have language that states the contracted payment is accepted as payment in full with no patient balance billing.

Benefit:

Healthcare services that an insurance company contracts to provide to a patient. Sometimes called a covered service. An example of a benefit could be emergency care. This means if emergency care is a benefit, and the patient (member) goes to the emergency room and it is determined that the medical condition is an

emergency, the insurance company pays the benefit claim. How much is the cost of the benefit. That varies per patient or member policy (contract). The contract could require the benefit payment to be 100% of the member's out of pocket medical expenses. It could also be based on a percentage of the insurance company's usual and customary reimbursement amount. This could be 60%. The insurance company may allow \$100 for usual and customary. Therefore, it would pay \$60. The patient's contract may require the patient to pay the other \$40 plus the difference between the providers charge and the allowed amount. If the service is NOT a benefit or a covered service, it may be possible to have the patient pay for the service.

Catastrophic Cap:

Catastrophic cap limits the amount of out-of-pocket expenses a patient will have to pay for TRICARE-covered medical services. The cap applies to all covered services—annual deductibles, pharmacy co-pays. Once the patient meets the catastrophic cap, there are no more out of pocket expenses. The claim is paid at 100% of the Tricare allowable.

COB – Coordination of Benefits:

Sometimes a patient will have more than one health insurance policy. This could be a patient with Medicare and Medicaid. Medicaid is usually the health care benefit that is billed last. The patient could have Medicare and coverage under the Veterans Administration. The patient could be covered under health care provided as a benefit of employment through their own employer or through their spouses employer. If so, the two insurance companies are required to determine which policy is primary or which is secondary. Cob also includes other factors such as birthdate of parents who is providing healthcare to a child. Some states have laws regulating coordination of benefits.

For example, in Florida, you have the following:

627.4235 Coordination of benefits.--

(1) A group hospital, medical, or surgical expense policy, group health care services plan, or group-type self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses delivered or issued for delivery in this state must contain a provision for coordinating its benefits with any similar benefits provided by any other group hospital, medical, or surgical expense policy, any group health care services plan, or any group-type self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses for the same loss.

(2) A hospital, medical, or surgical expense policy, health care services plan, or self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses issued in this state or issued for delivery in this state may contain a provision whereby the insurer may reduce or refuse to pay benefits otherwise payable thereunder solely on account of the existence of similar benefits provided under insurance policies issued by the same or another insurer, health care services plan, or self-insurance plan which provides protection or insurance against hospital, medical, or surgical expenses only if, as a condition of coordinating benefits with another insurer, the insurers together pay 100 percent of the total reasonable expenses actually incurred of the type of expense within the benefits described in the policies and presented to the insurer for payment.

(3) The standards provided in subsection (2) apply to coordination of benefits payable under Medicare, Title XVIII of the Social Security Act.

(4) If a claim is submitted in accordance with any group hospital, medical, or surgical expense policy, or in accordance with any group health care service plan or group-type self-insurance plan, that provides protection, insurance, or indemnity against hospital, medical, or surgical expenses, and the policy or any other document that provides coverage includes a coordination-of-benefits provision and the claim involves another policy or plan which has a coordination-of-benefits provision, the following rules determine the order in which benefits under the respective health policies or plans will be determined:

(a)1. The benefits of a policy or plan which covers the person as an employee, member, or subscriber, other than as a dependent, are determined before those of the policy or plan which covers the person as a dependent.

2. *However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:*

a. First, benefits of a plan covering a person as an employee, member, or subscriber.

b. Second, benefits of a plan of an active worker covering a person as a dependent.

c. Third, Medicare benefits.

(b) Except as stated in paragraph (c), if two or more policies or plans cover the same child as a dependent of different parents:

1. The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before the benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls later in that year; but

2. If both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time.

However, if a policy or plan subject to the rule based on the birthdays of the parents coordinates with an out-of-state policy or plan which contains provisions under which the benefits of a policy or plan which covers a person as a dependent of a male are determined before those of a policy or plan which covers the person as a dependent of a female and if, as a result, the policies or plans do not agree on the order of benefits, the provisions of the other policy or plan determine the order of benefits.

(c) If two or more policies or plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. First, the policy or plan of the parent with custody of the child.

2. Second, the policy or plan of the spouse of the parent with custody of the child.

3. *Third, the policy or plan of the parent not having custody of the child.*

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the policy or plan of that parent has actual knowledge of those terms, the benefits of that policy or plan are determined first, except with respect to any claim determination period or plan or policy year during which any benefits are actually paid or provided before the entity has the actual knowledge.

(d) The benefits of a policy or plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a policy or plan which covers the person as a laid-off or retired employee or as the employee's dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph does not apply.

(e) If none of the rules in paragraph (a), paragraph (b), paragraph (c), or paragraph

(d) determine the order of benefits, the benefits of the policy or plan which covered an employee, member, or subscriber for a longer period of time are determined before those of the policy or plan which covered the person for the shorter period of time.

(5) Coordination of benefits is not permitted against an indemnity-type policy, an excess insurance policy as defined in s. 627.635, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

(6) If an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidation Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 99-272), and also under another group plan, the following order of benefits applies:

(a) First, the plan covering the person as an employee, or as the employee's dependent.

(b) Second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA.

In Missouri, you have the following:

20 CSR 400-2.030 Group Coordination of Benefits

PURPOSE: This rule restricts the use of coordination of benefits provisions in group health insurance plans to those situations where they may be equitably applied.

(1) Applicability. The purpose of this rule is to—

(A) Permit, but not require, plans to include a coordination of benefits (COB) provision;

(B) Establish an order in which plans pay their claims;

(C) Provide the authority for orderly transfer of information needed to pay claims promptly;

(D) Reduce duplication of benefits by permitting a reduction of the benefits paid by a plan where the plan, pursuant to rules established by this rule, does not have to pay its benefits first;

(E) Reduce claims payment delays; and

(F) Make all contracts that contain a COB provision consistent with this rule.

(2) Definitions. The following words and terms, when used in this rule, shall have the following meanings unless the context clearly indicates otherwise:

(A) Allowable or Allowable expense.

1. Allowable or Allowable expense means the necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

2. Notwithstanding this definition, items of expense under coverages, such as dental care, vision care, prescription drug or hearing-aid programs, may be

excluded from the definition of allowable expense. A plan which provides benefits only for any of these items of expense may limit its definition of allowable expenses to like items of expense.

3. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

4. The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

5. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of allowable expense must include the corresponding expenses or services to which COB applies.

6. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of this reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services and preferred provider arrangements.

A. Only benefit reductions based upon provisions similar in purpose to those described previously and which are contained in the primary plan may be excluded from allowable expenses.

B. This provision shall not be used by a secondary plan to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services. Note: Paragraph (2)(A)6. Is not intended to allow a secondary plan to exclude expenses that are applied towards the satisfaction of the deductible, copayments or coinsurance amounts required by the primary plan, except for the benefit reductions expressly described in this paragraph;

(B) Claim. A request for benefits of a plan to be provided or paid is a claim. The benefit claimed may be in the form of—

- 1. Services (including supplies);*
- 2. Payment for all or a portion of the expenses incurred;*
- 3. A combination of paragraphs (2)(B)1. and 2.; or*
- 4. An indemnification;*

(C) Claim determination period. This is the period of time, which must not be less than twelve (12) consecutive months over which allowable expenses are compared with total benefits payable in the absence of COB, to determine whether over insurance exists and how much each plan will pay or provide.

1. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

2. As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period;

(D) Coordination of benefits. This is a provision establishing an order in which plans pay their claims;

(4) Rules for Coordination of Benefits— Order of Benefits.

(A) General. The general order of benefits is as follows:

1. The primary plan must pay or provide its benefits as if the secondary plan(s) did not exist. A plan that does not include a coordination of benefits provision may not take the benefits of another plan as defined in subsection (2)(F) into account when it determines its benefits. There is one (1) exception—a contract holder’s coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder; and

2. A secondary plan may take the benefits of another plan into account only when, under these rules, it is secondary to that other plan.

(B) Order of Benefit Determination. Use the first of the following rules which applies:

1. Nondependent/dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent, except that, if the person is also a Medicare beneficiary and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is—

A. Secondary to the plan covering the person as a dependent; and

B. Primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent;

2. Dependent child/parents not separated or divorced. The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;

B. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

C. The word birthday refers only to the month and day in a calendar year, not the year in which the person was born; and

D. If the other plan does not have the rule described in subparagraphs

(4)(B)2.A.–C. and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

3. Dependent child/separated or divorced parents. If two (2) or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody of the child; and

C. Finally, the plan of the parent not having custody of the child;

D. If the specific terms of a court decree state that one (1) of the parents is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent or spouse of the other parent shall be the secondary plan(s). This subparagraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge; or

E. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health

care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (4)(B)2., dependent child/parents not separated or divorced;

4. Active/inactive employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Some health insurance plans describe Coordination of Benefits in the Benefit Manual or Summary Plan Description (SPD). For example, the following is from an employer SPD: Coordination of Benefits (COB) applies when an individual has health care coverage through more than one group program. The purpose of COB is to insure that the individual receives all of the coverage for which the individual is entitled, but no more than the actual cost for the care received. In other words, total payments from all of the insurance coverage combined cannot be more than the total charges incurred.

As you can see, COB can be very complicated. Lets look at the following examples:

EXAMPLE: SFC Stewart Lee is former military with veterans benefits. He resides in Orlando, Florida. His place of veterans treatment is the VA hospital located in Tampa, Florida. SFC Lee also has Medicare Part B as coverage. SFC Lee was seen at the Our Lady of The Blessed Acne hospital in Orlando. He asks that the claim be sent to Medicare Part B. Medicare know SFC Lee has coverage through the Veterans Administration. In this case, either Medicare or the VA is primary. Medicare doesn't pay for what the VA doesn't pay and the VA doesn't pay for what Medicare doesn't pay. Once Medicare makes its payment, SFC Lee can be responsible to the provider for any co-insurances and deductibles. Under normal circumstances with commercial health insurance, you might send the Medicare EOB to the commercial insurance company. Two things could happen. The insurance company could pay the coinsurance and/or deductible or they could

deny payment by stating they don't pay anything more than what the primary insurance company paid. This may be a clause in the patient's health insurance contract. However, KNOW YOUR STATE COB LAW. With Medicare and the VA, SFC Lee cannot ask that the Veterans Administration be billed to pay what he owes. If SFC Lee asks that the VA be billed first, any payment that is made by the VA is considered as payment in full. I once had a SFC Lee case. He said WE made a mistake in billing Medicare. However, we followed his telephonic instructions. We refilled the claim to the VA, they paid what they would normally pay and we refunded Medicare the payment they made. From that point on, it became office compliance policy that under NO circumstance was a patient claim with Medicare and VA to be sent to Medicare without written instructions from the patient.

Last, when working for a physician, make sure you read the providers contract regarding COB. The provider may be contracted with Blue Cross and Blue Shield. The patient may have BCBS as primary or secondary. It is important to know how your claim will be paid when sent as secondary with BCBS or with BCBS as a Medicare HMO. The patient may have United healthcare as primary. They paid \$120 of a \$150 claim. The contract with BCBS may pay 80% of the Medicare allowable. The allowable may be \$100, so all the provider is entitled to be paid as a contracted provider. The claim as secondary may be denied as the primary paid more than the contracted amount. Knowing your COB law can help you fight back.

Capitation:

This term can have many meanings. Capitation represents a set dollar limit that is paid to a provider by an insurance company for treating their members. This set dollar limit can be based on a monthly dollar amount, a per patient dollar amount or a per claim dollar amount. The insurance company can say that they will pay the provider \$3,000 per month. This can equate to \$10 per day. If the provider treats 10 patients per day, the provider makes \$1.00 per patient per visit. The provider may be required to submit a claim but there won't be any additional payment on the claim. The payment per claim could be \$90 per claim. This means you send a claim and each claim should be paid \$90 regardless of how many codes

are submitted. With a per claim payment, the biller must keep a close eye on the claim payments, this is because some insurance companies will pay the claim less than the amount agreed upon in the contract. This will require you to appeal the incorrect payment and continue until it is paid correctly. Before agreeing to a capitated amount, the provider should make sure the capitated amount is fair and reasonable. This is something that will be discussed more in another document on Insurance Contracts.

Carrier:

This is nothing more than a shorter name for an insurance company. For example. First Coast is the local carrier for Medicare Part B for Florida and Georgia. Another example would be, \$75 is the usual and customary reimbursement amount for the carriers in our geographical area. In simplistic terms, all the insurance companies in our area pay \$75 for a claim.

Claim:

A written request by a patient, or insured member submitted to their health insurance carrier, to have their health benefit paid. If a provider is contracted with the patient's insurance company, the provider has agreed to send the claim on behalf of the patient or member. If the Medicare care provided is a benefit allowed under the patient's contract, then the benefit is paid. How much is paid depends on the patient's contract or provider's contract. The patient's contract may require the carrier to pay a percentage of their usual and customary reimbursement amount with the patient paying the balance of the usual and customary in addition to any amounts applied to their deductible or the difference between the provider's charges and the insurance company's usual and customary allowed amount. The medical biller should have knowledge of how the carrier pays the claim per the patient's contract and per the contract between the provider and carrier. If the insurance company sends payment of the claim to the provider, the provider applies the payment to the debt owed by the patient. The patient may have a secondary insurance which might pay any deductibles and/or the coinsurance amounts and/or the difference between the charges and payment. This would entail sending a claim to the patient's other insurance carrier. When sending a claim to the secondary carrier, you will need to attach a clean EOB from the primary. A

clean EOB means you have removed any reference to other patients listed on the EOB. You do this as part of HIPAA privacy. The ways to do this could be to white out the other patient information or using a black marker, then making a photocopy so you cannot see through and view other patients private and personal health information. I use paperport, a scanning program. Using paperport, I can scan the original EOB, then delete any other patient information. Once removed, I can print the changed EOB so that only the current patient's information is shown. There is no need for white out or a black marker. I also have an undamaged original EOB if needed. To finalize, claims can be sent by paper using a CMS 1500 form for outpatient and provider services. Hospital inpatient claims can be sent using a paper UB04. Instructions on each form are found in a separate publication.

CMS – Centers for Medicare and Medicaid Services:

CMS is a Federal Agency responsible for overseeing and regulating Medicare and Medicaid. CMS come under the jurisdiction of the Department of Health and Human Services. CMS is also the agency responsible for monitoring and approving the code sets (CPT and ICD-9) under HIPAA. Medicare HMOs come under the jurisdiction of the area CMS offices. Medicaid HMOs come under the jurisdiction of a State Medicaid agency. CMS used to be called HCFA, the Health Care Financing Administration.

CMS 1500:

The CMS 1500 is the current HIPAA approved standard paper claim form submitted to insurance companies to have the outpatient health benefit or the contracted provider visit paid. The CMS 1500 form is designed by the National Uniform Claim Commission. Most insurance companies desire to have the CMS 1500 form sent to them in an electronic format. The fields or blocks on the form are the same regardless if on paper or done electronically. The CMS 1500 claim form instructions can be found here:

http://www.nucc.org/images/stories/PDF/claim_form_manual_v3-0_7-07.pdf

Coding:

The process of converting a medical procedure, a surgical procedure, a hospital inpatient stay or a doctor visit to a CPT code. The medical diagnosis is converted to an ICD-9 code. Some supplies are converted to HCPCS Codes. The purpose of coding is to document the reason for the visit or service and what was done during that visit so that the insurance company's computers can quickly recognize the coded numbers and process the claim for payment.

Co-Insurance:

Co-insurance refers to an amount that a patient or insured person is contractually required to pay for medical care, after a deductible has been applied. In some health care plans, co-insurance is called "co-payment." Co-insurance is often specified by a percentage. For example, with some patient contracts, the patient or member's coinsurance may require them to pay a percent toward the charges for a service and the employer or insurance company pays a higher percent. A good example is with Medicare. Medicare pays 80% of their allowed amount. The patient must pay an annual deductible plus 20% of the allowable. This 20% is called co-insurance. You can see this on the Medicare EOB or remittance as COINS. Co-insurance is separate from a deductible.

Contracted Provider:

Also called a Par or Network provider. This is a physician, hospital or other medical care provider such as an Advanced Registered Nurse Practitioner (ARNP) or Physician's Assistant (PA) that has agreed to be contracted with the patient's health insurance company. This contract is a legal and binding document. The provider should have any contract reviewed by an experienced attorney before the signing of the contract. The contracted provider has agreed to send claims for the patient, be paid at an amount that is less than the provider's usual and customary charges. For example, for an office visit, the provider may usually charge \$125. The provider contracted to be paid 120% of the Medicare allowable fee. Medicare may allow \$100 for the service, so the provider agreed to be paid \$120 rather than \$125. Very few insurance companies will allow close to 100% of the Medicare allowable. Most want to reimburse less than the Medicare allowable.

Co-Payment:

Co-payment or co-pay is a predetermined (flat) fee, based on a contract between an employer or patient and an insurance company. A co-payment that a patient pays for health care services is in addition as an out of pocket expense to what the insurance company covers for the service provided. A co-pay is separate from a deductible and co-insurance. For example, a patient may have coverage through Blue Cross and Blue Shield. The policy may require the patient to pay a \$10 co-payment for each office visit, regardless of the type or level of services provided during the visit. A patient coming in for daily blood pressure checks could be required to pay the co-pay for each BP check visit. Co-payments are not usually specified by percentages. Co-pays are usually paid at the time of service. Some providers will bill the patient for the co-pays. A huge question that is always asked is, "Can we write off the co-pay owed by the patient. This question has NO easy answer. Again, the co-pay is a contractual amount that the patient is required to pay. Writing off co-pays on a routine basis could be determined by a Government Inspector as an incentive to have the patient make referrals to the provider. The insurance company could take the position that writing off a co-pay is a contract violation. The key word with doing a write off is routine. Each write off should be on a case by case basis. The patient may be financially unable to pay the co-pay. If, so then it would be permissible to write off the co-pays. There are at least three (3) acceptable means of writing off what a patient may owe. (1) The provider has made every effort to make collection on what is owed and this includes a debt collection agency. (2) if it would cost more to collect than what is owed. For example, the patient owes \$1.95. It costs \$10 in administrative expenses to bill a patient. Therefore the cost to collect is more than what is owed. The \$1.85 could be adjusted off as a small balance adjustment, and (3) The patient is financially unable to pay. The patient must prove they are financially unable to pay. This can be in the form of wage statements, bank statement, tax statement and lists of monthly bills such as electricity, food, and other bills.

COBRA: Consolidated Omnibus Budget Reconciliation Act.

This is a Federal Law that allows a worker to continue to purchase employer paid health insurance for up to 18 months if you lose your job or your coverage is otherwise terminated. For example, your employer provides you with health insurance through United Healthcare as a benefit of employment. The employer is going out of business or you leave for another job. Under COBRA, you can continue to keep your United Healthcare coverage when you leave your employer.

The catch to this is that YOU must continue to pay the premiums that your employer paid. Some people decline this because they can't afford the premiums. If the patient kept the COBRA coverage make sure you verify that the coverage is still in effect at the time of service. The patient may present the United healthcare insurance card but you find out that the patient did not pay the premiums, so the coverage was terminated.

Conditional Payment:

A Medicare payment for services for which another insurer is primary payer.

Conditional Primary Medicare Benefits: conditional primary Medicare benefits may be paid if:

- a. The beneficiary, the physician, or the supplier has filed a proper claim with a TPP in the case of services for which payment under WC or no-fault insurance can reasonably be expected, and you determine that the insurer will not pay promptly
- b. The beneficiary, the provider, or the supplier that has accepted assignment filed a proper claim with a GHP or LGHP and the TPP denied the claim in whole or in part; or
- c. Because of physical or mental incapacity of the beneficiary, the physician, supplier, or beneficiary failed to file a proper claim with the TPP.

Covered Service:

Health benefits which are allowed per a contract with a health insurance company or a health benefit allowed by Medicare, Medicaid, Tricare or Workers Compensation.

CPT – Current Procedural Terminology:

CPT is a list of procedure codes owned, copyrighted and developed by the American Medical Association. A procedure is something that the doctor does to a patient during a visit. For example, if you cut your finger and the doctor repairs the cut, there is a procedure code to put on the claim form. The code is recognized by coders, and insurance company claims software. Let's look at the cut on the

finger. To convert the repair to a CPT code, you need to know the length of the wound, in centimeters so you can select the correct CPT code. For the purpose of this example. You have a 1cm simple cut on your index finger. The repair of this cut would be 12001. Every procedure performed MUST be supported by a correct diagnosis code or ICD-9 code. The diagnosis or ICD-9 code for an unspecified wound of the finger would be 883.0. Now, if you saw ICD-9 code 042 used with CPT code 12001, you would be confused. That would be like saying the doctor sutured the patient's finger cut because the patient had AIDS. Therefore it doesn't make sense to suture a wound if there is no open wound diagnosis.

Deductible:

A deductible is a contractual amount that the patient is required to pay as an out of pocket expense before the insurance company pays any claim sent to them. The amount of deductible varies per patient and per insurance policy. Commercial insurance and Medicare deductibles start in January of each year. Tricare deductibles start in October each year. A patient may have a \$1,000 deductible. The patient is seen by the doctor on January 5th. The claim is for \$250.00. The insurance company allows \$100 for the benefit or covered service. The patient hasn't met their deductible yet. The \$100 is applied to the deductible. Now the patient has a \$900 deductible to meet before the claim is paid by the insurance company. The patient comes in each month for the next 9 months. The claim is sent in September. The \$100 is applied to the remaining deductible. If the patient comes in the next month (October), the deductible has been satisfied, so now a check will be sent by the insurance company. Whether the patient actually pays the deductible is between the provider and patient. The insurance company doesn't care if the patient doesn't actually pay the deductible. All this means is that with a \$1,000 deductible, with \$100 allowed for the visit it will take 10 visits before the insurance company will release any money to pay the patient's claim. Medicare does care if the provider collects the deductible from the patient.

Dependents:

A Spouse and/or an unmarried child (whether natural, adopted or step) of an insured person. When looking at the insurance card (other than Medicare) you may see the policy number and at the end, you may see 01, 02, 03, 04 or another 2 digit number. These numbers have meaning, but could vary per insurance company.

00: Insured or member (Some insurance companies may have 01 as the insured)

01: Spouse

02: Eldest child/adopted child or step child

03: Next eldest child/adopted child or step child.

When it comes to children, if the child is over the age of 18, the child is legally an adult. The adult child may or may not be listed on the policy of the parent(s). AN exception is when the adult child is a full time student. Some insurance companies may demand proof of student enrollment before any claims are processed. You, as a medical biller, must always protect the personal health information of any adult children. Some parents may call and ask why their child was treated. Unless you have written permission , from the adult child, to release this information, you must continue to protect the privacy of the adult child, even when threatened by the parent.

Denial:

When an insurance company will not pay a benefit or contracted claim. There can be several reasons why the claim is denied:

- 1) The service was not covered under the patient's health insurance contract.
- 2) The claim was allegedly received in an untimely manner.
- 3) The service was considered as not being medically necessary.
- 4) There is another insurance company that is primary.
- 5) The procedure or service submitted is included with another procedure or service being billed at the same time.
- 6) The patient's policy was terminated with NO COBRA continuance.
- 7) The medical condition was deemed by the insurance company as being pre-existing.
- 8) The patient's policy is new and not effective on the date services were provided.

- 9) Authorization or Precertification was not obtained prior to rendering the service.
- 10) Benefits ran out. In other words, the patient may have been limited to a certain number of visits. This can usually happen with chiropractic visits.
- 11) The patient's insurance policy is not in effect at the time of service.

Denials should be reviewed and appealed if the denial is incorrect, based on documented evidence to support the appeal.

DHHS (Department of Health and Human Services)

Department of Health and Human Services is the governmental agency in charge of Medicare and Medicaid. DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. (It is the "parent" of the Centers for Medicare and Medicaid Services).

DOS (Date of Service)

The date(s) associated with when a provider treats or evaluates a patient for their medical condition. For example if a patient came to see a doctor on January 1, 2009, the DOS would be January 1, 2009.

DME: Durable Medical Equipment:

Medical equipment which: can withstand repeated use; is not disposable; is used to serve a medical purpose; is generally not useful to a person in the absence of sickness or injury, and is appropriate for use in the home. Examples include hospital beds, wheelchairs and oxygen equipment.

EBSA (Employee Benefits Security Administration)

The Employee Benefits Security Administration (EBSA) is the Federal Governmental Agency responsible for the enforcement of the ERISA Law. The EBSA is a branch of the Department of Labor.

EDI (Electronic Data Interchange)

Electronic Data Interchange is the exchange of claims information and claims transactions from one computer to another in a standard format, using standard

communications protocols. When sending claims to Medicare or Medicaid, electronically, one must usually fill out an EDI application and follow the EDI requirements of the insurance company.

EGHP (Employer Group Health Plan)

A health plan that 1) Gives health coverage to employees, former employees, and their families, and 2) Is from an employer or employee organization.

EIN (Employer Identification Number)

An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number, and is used to identify a business entity. Generally, businesses need an EIN. Any business can apply for an EIN through the Internal Revenue Service such as via Mail or via online. You must check with your state to see if you require a State tax ID number.

Effective Date:

Some people may not think this is very important, but the effective date is the date the insurance policy is to begin or when benefits or covered services are allowed. The patient may not be covered until the policies effective date. Some patients may leave one employer and be hired by a new employer. The old employer must inform the insurance company whether the employee (patient) if the employee is no longer covered under the employer's policy. Example: Mrs. Smith worked for Paymore Shoe Store. Paymore provided health care coverage through Aetna. The policy was effective as of January 5, 1995. Mrs. Smith left Paymore on March 2, 2008. Mrs. Smith now works for Dewey Cheatem and Howe as a Paralegal. She started on May 20, 2008. Dewey provides employer sponsored HMO through Cigna. The effective date for Cigna is May 20, 2008. Between March 2, 2008 and May 20, 2008, Mrs. Smith was still covered under Aetna between jobs because she chose to continue her Aetna coverage through COBRA. Today is June 15, 2008, Mrs. Smith walks into the local urgent care center. She presents her old Aetna insurance card. You check and Aetna shows an effective date of January 5, 1995, but an expiration date of May 19, 2008. You bring this to Mrs. Smith's attention and she is adamant she is still covered by Aetna. Mrs. Smith doesn't know her Aetna coverage terminated when she was hired by Dewey and Dewey started providing her with Cigna. Now you can see, how confusing Medical billing can be. As a properly trained medical biller, you know how to resolve multiple coverage issues. In this case, you find out Cigna is now her covered policy. Mrs. Smith now provides her Cigna card. You have checked and found

her effective date with Cigna. You use this information in case Cigna denies the claim due to the policy not being in effect at the time of service.

ERISA (Employee Retirement Income Security Act) :

ERISA is a Federal law that was enacted in 1974. It was originally created to safeguard an employees retirement benefits. As employers began to offer health care as a benefit of employment, healthcare was added to the law. There are many parts of this Federal law, but the specific ones are 29 USC 18, 1003(A), which states the following:

Except as provided in subsection (b) or (c) of this section and in sections 1051, 1081, and 1101 of this title, this subchapter shall apply to any employee benefit plan if it is established or maintained -

(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or

(2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or

(3) by both.

(b) Exceptions for certain plans

The provisions of this subchapter shall not apply to any employee benefit plan if -

(1) such plan is a governmental plan (as defined in section 1002(32) of this title);

(2) such plan is a church plan (as defined in section 1002(33) of this title) with respect to which no election has been made under section 410(d) of title 26;

(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;

(4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or

(5) such plan is an excess benefit plan (as defined in section 1002(36) of this title) and is unfunded

You will notice that ERISA does not discriminate. It includes PPOs, POS and HMO benefit plans.

Another section of the ERISA Law that HMOs have used to their benefit as far as The United States Supreme Court, in the cases of Davilla vs Aetna and Calad vs Cigna. This section is 29 USC 18, 1144(a), which is worded as follows:

Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

Basically, the two HMOs were being sued using State HMO laws. The HMOs went before the U.S. Supreme Court, using this section of ERISA and stated that the State HMO law is superseded by ERISA. The Supreme Court agreed with the HMOs. What you need to be in the watch for is when the HMO wants protection of both a State HMO law and ERISA. The other part of ERISA you should know is 29 CFR 2560-503-1. This part establishes the claims/benefit payment, and appeals process of an ERISA plan. The Department of Labor has jurisdiction over an ERISA Benefit. I do not recommend trying to use ERISA. I suggest leaving ERISA to a lawyer or the experts.

ESRD (End Stage Renal Disease)

This is a patient who is suffering from Kidney Failure and could soon become deceased due to kidney failure. Some ESRD patients have applied and have been approved by the Social Security Administration for Social Security Benefits and Medicare Parts A and B.

Exclusions:

Medical services that are not covered by an individual's insurance policy. For example, Medicare does not cover routine annual physicals. To find out what is excluded or not covered, you need to check with the insurance company or look at the patient's benefit manual. Look at your own benefit manual or summary plan description to see what medical care is not covered under your policy. If the service requested by the patient is excluded or not covered, you need to explain this to the patient so that the patient is aware of their financial responsibility for paying

for excluded or non-covered services. This allows the patient the freedom of choice to leave or to continue with the care knowing the financial requirements. Medicare requires providers to do with with all Medicare patients regarding services that may be denied. The patient must sign an ABN (Advanced beneficiary Notice) form.

EOB: Explanation of Benefits:

When an insurance company processes a claim for health benefits or a claim for a provider contract, it produces a report of how the claim was processed. The claim will be (a) paid, (b) denied or (c) pended. When paid, the medical biller checks the EOB to determine if the claim was paid correctly either per the provider's contract or per the patient's contract. Sometimes a claim was sent with multiple procedures but some were left off the EOB. The biller should check to make sure all CPT codes submitted are on the EOB. The biller should check the allowed amount. Some insurance companies may have an allowed amount that is less than the billed charges. If the provider is non-par, any allowed amount that is less than billed charges should be unacceptable. However, the insurance may pay the non-par claim at the amount pursuant to their contract with their member. However, the member would usually be required to pay the difference between the insurance company payment and billed charges. If the claim is to Medicare or Medicaid, the allowed amount would be the Medicare/Medicaid allowed amount. One thing the biller can do is create a cheat sheet in spreadsheet showing the CPT codes used by the provider. The cheat sheet will list the charges, the Medicare and Medicaid allowable amounts. And any provider contract amounts. I also like to add State workers compensation fees payable per CPT code. This way you have easy access to payment amounts due to the provider by contract, workers comp, Medicare and Medicaid. If there are amounts less than billed charges, any amounts applied to the deductible or coinsurance, the EOB will show this as well as have remark codes and remark code descriptions. For example, let's say you see remark code X20. On the EOB you may see X20: Allowed amount is based on contract allowed amount. Sometimes the remarks don't have any sane meaning. You may have to contact the insurance company and ask them what that remark code means. If the provider is non-par watch out for remarks that mention contract discounts or discounts applied to benefit the member. To be honest, the only one being benefitted by a discount is the insurance company, not the member. The insurance company may have sent a facsimile or phone call to the provider asking the provider to accept a discount to the payment. If this happened, you should have been informed of any interim agreements made on individual discounts. Some

insurance companies will offer a 20% discount for that one patient. The same insurance company may see how much they can get away with, so they apply the discount to other claims. You need to be on top of any contracts and discounts agreed to by the provider. If the insurance company posted a remark that a contract discount, you should contact the insurance company to let them know no contract exists. The insurance company may be insistent that there is a contract with the provider. I would ask them to send me a copy. If I don't receive anything within 14 calendar days, then I do not accept their discount. Normally you won't receive anything because there is no contract. The insurance company may try to intimidate you by saying they will turn this issue over to their fraud division. I usually welcome this because with all the threats of having the situation being turned over to their fraud division, nothing ever happened. Another trick you may see is when you have multiple page EOBs. Usually on the next to last or last page will have a very tiny remark which says, "Acceptance of this check could be viewed as payment in full" This remark is known as an accord and satisfaction. The insurance company, by making this statement as an offer to pay less than what is due, so by cashing the check, you agree to the offer or accord or you satisfy the accord. Some providers use bank lock boxes to process checks. The bank doesn't see the accord and satisfaction statement on the EOB, It is also not shown on the check. When the bank processes the check, the insurance company takes the stand that the provider was offered an accord and satisfied the accord through his representative, the bank. We had our attorney resolve this. A stamp was prepared with legal language allowing the check to be cashed. The lawyer had this practice ceased. Sometimes the EOB is accompanied by a benefits check. If so, then make sure the amounts of payments on the EOB match the dollar amount on the check.

FFS (Fee-for-Service):

Also known as indemnity insurance, FFS is a type of health coverage that typically allows a patient to go to any doctor or provider without permission. Under old FFS policies, the insurance company would pay 100% of the charges that were submitted. Many insurance companies no longer sell a FFS policy, but due to the volume they originally sold, there may be a few patients with a FFS policy still around. The insurance company may decide to pay a non-par provider its UCR fee. Contracted providers would be paid the contracted reimbursement fee.

Fraud:

Obtaining or attempting to obtain services or payments by dishonest means with INTENT, KNOWLEDGE and WILLINGNESS to result in an unauthorized benefit to the provider or another person.

- Accepting or offering kickbacks, bribes or rebates
- Using another person's Medicare card or number
- Billing for items or services that were not provided
- Billing twice for the same service either on the same date or a different date
- Billing for non-covered services and disguising them as covered services.

Examples are: routine eye examinations, dental services, hearing related services, routine foot care services, etc.

- Billing both Medicare and another insurer, or the patient, in a deliberate attempt to be paid twice.

Fraud should not be confused with making honest mistakes. The key word with fraud is Deliberate.

GHP (Group Health Plan):

Group Health Plan means any arrangement of, or contributed to by, one or more employers, or employee organizations, to provide health benefits or medical care directly or indirectly to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is considered to be a single plan if it provides for common administration of the health benefits (e.g., by the employers directly or by a benefit administrator or by a multi-employer trust or by an insuring organization under a contract or contracts). GHPS normally come under the jurisdiction of ERISA.

HIC (Health Insurance Claim)

HIC is a number assigned by the Social Security Administration to an individual identifying him/her as a Medicare beneficiary. This number is shown on the

beneficiary's insurance card and is used in processing Medicare claims for that beneficiary.

HCPCS (Healthcare Common Procedure Coding System)

HCPCS pronounced HicksPicks is a set of codes in addition to the American Medical Association's Current Procedural Terminology (CPT)

HCPCS was established in 1978 to provide a standardized coding system for describing the specific items and services provided in the delivery of health care. Some examples are drugs, immunizations, bandaging materials, DME equipment, and ambulance transporting. With the implementation of HIPAA (Health Insurance Portability and Accountability Act of 1996) the use of HCPCS became mandatory along with CPT and ICD-9. This is because prior to HIPAA every insurance company could have their own internal codes or “local codes”. HIPAA established a universal set of codes for providers, billers and insurance companies to use. The use of local codes was abolished. Insurance companies had to convert their local codes to CPT, ICD-9 and HCPCS. HCPCS has its own separate code manual.

HCPCS includes three levels of codes:

Level I consists of the American Medical Association's Current Procedural Terminology (CPT).

Level II codes are alphanumeric and primarily include non-physician services such as ambulance services and prosthetic devices, and represent items and supplies and non-physician services not covered by CPT codes (Level I). Level II alphanumeric procedure and modifier codes are a single alphabetical letter followed by 4 numeric digits; the first alphabetic letter is in the A to V range. Level II codes are maintained by the US Centers for Medicare and Medicaid Services (CMS). There is some overlap between HCPCS codes and National Drug Code (NDC) codes, with a subset of NDC codes also in HCPCS, and vice-versa. The CMS maintains a crosswalk from NDC to HCPCS in the form of an Excel file. The crosswalk is updated monthly.

Level III codes, also called local codes, were developed by state Medicaid agencies, Medicare contractors, and private insurers for use in specific programs and jurisdictions. The use of Level III codes was discontinued on December 31, 2003, in order to adhere to consistent coding standards

Health Maintenance Organizations (HMOs):

Health Maintenance Organizations today are nothing more than an insurance policy that is sold to patients or employers. When you obtain an HMO policy, it comes with certain health benefits. Some benefits are excluded. It also has some rules you, as a patient, must follow, such as if you wish to seek medical care from an out of network or non-participating/non-contracted provider, you may have to have permission to do so from the HMO or your personal provider also known as your Primary Care Physician (PCP). Some HMOs only allow healthcare in a specific geographical area. One Florida HMO I know of only allows medical care if you obtain medical care in Miami/Dade county Florida. What this means is if you go to Disneyworld in Orlando (orange county), and you go to a doctor in Orlando, the HMO could deny the service. The exception is with emergency care, but, the determination of whether your emergency medical visit could be up to the HMO Medical Director. YOU could also face the possibility of having to pay for the medical care yourself if you don't follow the rules outlined by the HMO and placed in your benefit manual. HMO members should always know the rules of their HMO but many do not. Some states have specific HMO insurance laws. Texas and Florida are two states that have specific HMO laws that are similar. It is important to know that not all HMOs come under State Law jurisdiction. You have Medicare HMOs. Medicare HMOs come under the jurisdiction of the local offices of the Centers for Medicare and Medicaid services. YOU may also have an HMO plan provided by an employer as a benefit of employment. If this is so, the HMO may come under the jurisdiction of the Federal Law known as ERISA. See 29 USC 18, 1003(a), 29 USC 18, 1144(a) and 29 CFR 2560-503-1. ERISA HMOs also come under the jurisdiction of the Department of labor. Medicaid HMOs come under State Medicaid Law jurisdiction. So not all HMOs are equal.

HIPAA:

HIPAA, The Health Insurance Portability and Accountability Act is a Federal law that was passed in 1996. Part of the HIPAA Law (Privacy) HIPAA strengthened the privacy of the patient's personal health information (PHI). It also requires the

member or patient to be informed of any disclosures of their PHI. It also allows the patient to review their medical record and under some circumstances and with the providers approval, to make changes to the contents of their medical record. HIPAA allows the patient to have a copy of their medical record, if allowed under certain circumstances. HIPAA stated that the patient had to approve the transfer of PHI except for treatment, payment and healthcare operations. It also strengthened the security of PHI. It created the required use of a National Provider Identification (NPI) number. It mandated the use of what medical and administrative code sets (CPT and ICD-9) should be used because many insurance companies had their own internal codes.

ICD-9 (International Classification of Disease)

ICD is developed and copyrighted by the World Health Organization. ICD is a set of 3, or 5 digit codes that convert a disease, an injury or a history of a medical condition to a number or numbers. For example, Chicken Pox or Varicella has an ICD-9 code of 052.9. We use numbers so computers can recognize them quickly because insurance companies process millions of claims daily. The 9 means the 9th revision being used. Soon ICD-9 will be eliminated due to being outdated and because there are so many current codes that there will no longer be any room for new codes. ICD-9 will be replaced by ICD-10. Every year, in October, the codes are released and are effective. There are new codes, codes with different descriptions, and codes that are eliminated. Why do we have new codes? New diseases and injuries are identified. Sometimes world events happen such as with terrorism or a space accident such as the Columbia explosion, so now we have codes specifically designed for injuries caused as a result of terrorism or if you or the patient was injured in space. ICD has a strict set of rules for coders to follow., They can usually be found in the ICD manual. Some of these coding rules are developed by the insurance company as part of their internal coding policies.

In-network:

Physicians and Hospitals who contact with a health insurance company are called in-network providers. These providers agree to treat the insurance company

members at a discounted rate. In-network providers usually send claims on behalf of the patient and they can receive payment of the claim without an assignment of benefit form, however, the claim form must still annotate that the provider accepts assignment. Patients who use the services of an in-network provider must usually pay their out of pocket expenses such as co-pay, co-insurance, deductibles and non-covered services.

Indemnity Health Plan:

Indemnity health insurance plans are also called "fee for service." These are the types of plans that existed before the rise of HMOs, IPAs, and PPOs. With fee for service, the doctor sent the claim. If the charge was \$100, the insurance company paid \$100. Indemnity Plans are almost extinct with many insurance companies.

IPA: Individual Practice Association:

An IPA is composed of a group of physicians who maintain their own offices and group together for the purpose of contracting their services to HMOs, PPOs and POS plans. An HMO may contract with an IPA which contracts with independent physicians to treat members at discounted fees, on a capitation basis or on a fee for service reimbursement. The typical IPA encompasses all specialties, but an IPA can be solely for primary care or may be designed for a single specialty. The physician joining an IPA may be required to pay a membership fee. An example of an IPA is Central Oregon Independent Practice Association (COIPA) is comprised of nearly 600 physicians and practitioners within a 40,000 mile geographic area in Oregon who pay a yearly membership fee to maintain membership.

LOP (Letters of Protection):

When a person sustains an injury, they may or may not hire the services of an attorney to sue whomever caused their injury. Health insurance companies may or may not pay claims once a patient hires an attorney. If an attorney is hired, the case could take years to be resolved and settled. In some cases the lawsuit may be lost with no compensation being obtained. The attorney may send a Letter of Protection, requesting that the patient's account be placed on hold pending settlement of the case. This prevents the account from being sent to the provider's

debt collection agency due to delinquency. The LOP may also state that if there is a settlement, the provider agrees to be paid less than what is owed. Some providers do not accept Letters of Protection. Some providers require the patient to pay their bill and be reimbursed by any possible settlement.

Medicaid

A Federal health benefit program, managed by each State established for the financially needy, for the poor who are aged, blind, disabled or members of families with dependent children. Each state sets its own eligibility standards. Medicaid patients must be checked for eligibility every time they are seen by a provider. This is because the patient could be eligible one month, ineligible the next month and eligible the following month. In some states, a provider must be enrolled with Medicaid in order to be treated by a provider and for the provider to be paid by Medicaid. Medicaid providers agree to accept the Medicaid payment as payment in full.

Medicare – A federal health benefit program for people over 65, those with permanent disabilities that have been approved by Social Security, or patients with end stage renal disease. Medicare patients pay for Medicare out of their social security checks, which is automatically deducted. Medicare has four parts.

Part A: This part normally pays for covered inpatient services

Part B: This part normally pays for covered outpatient and provider services. Patients must apply for Part B coverage. Part B coverage has an annual deductible that the provider is required to collect from the patient. Some patient health insurance policies may or may not pay the Medicare Out of Pocket deductible.

Part C: Also called Medicare Advantage. This is a PPO or HMO plan which the patient may pay extra, for services not normally offered by Medicare. For example, Medicare Part B does not cover routine physicals. The Part C carrier may offer routine physicals as a covered service.

Part D: This part is the Drug prescription coverage.

Medicare claims are processed by Companies also called carriers or vendors, contracted by CMS. In some areas, the carrier is located within the State. For

example, in Florida, Medicare claims are processed by a company called First Coast. The claim is sent to the Medicare carrier for that State. For example, Mrs. Jenkins lives in New York but is on vacation in Florida. If she was seen in Florida, the claim would be sent to First Coast in Florida. Medicare requires providers to ensure Medicare eligibility prior to rendering medical care. The provider must also determine if the medical care is covered by Medicare. If the medical care may be possibly be denied such as Chiropractic services, the provider must inform the patient of the possibility of a denial. The provider has the patient sign an ABN form which allows the provider to bill the patient if the claim is denied. If the provider did not do this and the claim is denied, the provider is prohibited from billing the patient.

Medicaid Allowable:

The Medicaid allowable is the same as the Medicare allowable. Medicaid, is managed within each state. The Medicaid allowable is what has been established to pay for covered services rendered to a Medicaid patient. The difference between the Medicare and Medicaid allowable, is that Medicaid does NOT pay a percentage of the allowed amount. The allowed amount is paid to the provider that is enrolled with Medicaid. The amount paid is deemed to be payment in full with no patient responsibility. The provider has to write off or perform an administrative adjustment of the difference between the charge and the Medicaid payment.

Medicare Allowable:

The Medicare allowable is the reimbursement fee that Medicare allows for a covered service. Normally Medicare pays 80% of the allowable. The patient usually owes the 20% of the allowable. The provider is required to write off the difference between the charge and the allowed amount. For example, the charge may be \$125. Medicare allows \$100 for the covered service. Medicare pays the provider 80% of \$100 or \$80. The patient pays \$20. The doctor adjusts or writes off the \$25 which is the difference between the \$125 charge and the \$100 allowable amount. There is an exception to this. The provider has the option of accepting assignment with each claim. If the provider does not accept assignment, the payment of the covered service is sent to the member. Medicare allows the provider to collect 115% of the allowable to offset the cost of collecting from the

member. Example: Dr. Smith treats Mrs. Jones. Dr. Smith does not accept assignment on the claim. Why? We don't know. That is up to the doctor. Medicare allows \$100 and sends a check to Mrs. Jones for \$80. Dr. Jones is allowed to collect \$35 from Mrs. Jones. (115% of $\$100 = \115 . Medicare pays $\$80$. ($\$115 - \$80 = \35).

Medigap:

Health insurance coverage purchased by an person which is contracted to supplement Medicare coverage. Medigap health benefits may include payment of Medicare deductibles, co-insurance and balance bills, as well as payment for services not covered by Medicare. Medigap ceases when a patient obtains Part C or Medicare Advantage coverage. If the patient has Medicare and Medigap coverage, you must inform Medicare of this when you submit the claim to Medicare. You do this by putting the word "Medigap" and the Medigap policy number in block 19 of the claim form.

Med pay:

In some states this is called Personal Injury Protection (PIP). Both are a payment made by an insurer intended specifically to pay for medical expenses without regard to the fault of any part to the accident. Med-Pay is a form of no-fault insurance. In these situations, Medicare's proportionate share of procurement costs are not deducted from this payment unless the claim was contested.

MSA (Medical Savings Account)

Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis. Some MSAs require you to use all your savings before the end of the fiscal or calendar. Some allow you to carry over the unused funds at the end of the year. When using your MSA, you pay the medical expenses and submit your receipt/claim to the administrator of the MSA and you receive a check for the allowed amounts.

MSP (Medicare Secondary Payer):

MSP is the term used when Medicare is not responsible for paying first. The patient has health insurance that would be primary. Some examples would be with

Workers Compensation, Auto Insurance (PIP Coverage), A Group Health Plan when the patient is working and over 65 years of age. Medicare would NOT be a secondary payer if the patient was covered under VA or Veterans Administration benefits. The patient must decide to whom the claim is sent. The VA or Medicare. If the VA and the VA pays, the provider accepts the VA payment as payment in full. If Medicare, the patient is responsible for paying the Medicare coinsurance and deductibles.

You can obtain additional information on MSP here:

<http://www.cms.hhs.gov/manuals/downloads/msp105c03.pdf>

Non-Par (Non-Participating Provider):

Also known as out-of-network provider or a non-contracted provider.

The Non-par provider is not obligated to send a claim. The insurance company may send the payment of the health benefit to the member if the provider is non-par. Being non-par is an individual provider decision. The reasons could be many. The non-par provider may have been par or contracted at one time but may have terminated for reasons such as not being paid for services rendered, being paid less than the contracted amount, having claims downcoded by the insurance company or many other reasons.

OIG (Office of Inspector General)

The mission of the Office of Inspector General (OIG) is to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG's duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components.

OON (Out of Network)

When a patient obtains health insurance whether the insurance is a PPO, POS, or HMO plan, the patient normally selects a primary care provider. The PPO or POS plan may allow the patient to seek care from a non-par or non-contracted provider or an out of network provider without having to obtain permission to do so. When

the patient remains in network by seeking care from contracted providers, it saves the insurance company and patient money. The insurance company saves money by paying the par or in-network provider a contracted or agreed upon discounted reimbursement fee. The in-network provider, per contract with the insurance company cannot balance bill the patient for the difference between the charges and insurance (contracted) payment. The patient may only be required to pay their co-pay, co-insurance and deductible if not met. If the patient is an HMO member, their benefit contract may NOT allow them to go out of network to a non-par provider without the expressed permission of the HMO or Primary Care Provider (PCP) If the patient does go out of network, the claim could be denied entirely because no authorization was obtained or the claim could be paid at an out of network fee schedule established by the insurance company.

OOP (Out-of-Pocket) – the portion of the medical care costs for covered services that are required to be paid by the patient, including co-payments, co-insurance and deductible.

POS (Point-of-Service) – a health benefit plan allowing the patient to choose to receive a service from a group of contracted providers. This is similar to today's HMO plans. Some POS plans may not require preapproval or authorization to go out of network or to see a non-contracted provider. The insurance company may not pay anymore than what it pays when the patient is seen by a contracted provider. The patient usually assumes the extra costs for paying the difference between the providers charge and the insurance company payment.

PEC (Pre-existing Condition) – any medical condition that has been diagnosed or treated prior to a patient having current health insurance . Pre-existing conditions may not be covered for some specified amount of time as defined in the patients health insurance contract. Some insurance companies aggressively look for past medical conditions not defined in the patients enrollment form or health questionnaire so that they can terminate the coverage. These same insurance companies will go back 5 years or more to terminate coverage due to a pre-existing condition. They will send you a letter demanding the return of the claim payment they made years ago. You need to know your State Statute on pre-existing and State Statute on pre-existing. You can access each State Statute websites by going to: <http://www.llsdc.org/state-leg/>

Preferred Provider Organization (PPO) – a program that establishes contracts with providers. Providers that are contracted with an insurance company are called preferred providers by the insurance company. They are also called Par or In Network providers. Patients who belong to a PPO health insurance plan can usually seek care outside the network without having to obtain authorization or preapproval. The consequence of doing this means higher out of pocket expenses for the patient. The insurance company will pay the claim to the out of network provider. The patient pays all remaining costs. Some insurance companies will try their best to inform you that the patient does not owe anything more than what they, the insurance company, paid the non-par provider.

PIP (Personal Injury Protection):

is a State Mandatory form of auto insurance coverage. In some States, PIP coverage is mandatory. The amount of coverage differs from State to State. In Florida, PIP coverage is \$10,000. PIP covers medical expenses and, in some cases, lost wages and other damages. PIP is sometimes referred to as "no-fault" coverage, because the statutes enacting it are generally known as no-fault laws, and PIP is designed to be paid without regard to "fault," or more properly, legal liability. PIP is also called "no-fault" because, by definition, a claimant's, or insured's, insurance premium should not increase due to a PIP claim. Once PIP coverage is exhausted, claims will not be paid by the auto insurance carrier. The patient's personal health insurance may or may not cover the additional medical expenses. In some cases, the personal health insurance may deny all claims based on a third party liability.

Provider: Another name for a doctor, nurse, physicians assistant, physical therapist, or other health care person to renders or provides health care. In some State Laws, a hospital or health clinic is also defined as a provider.

Premium – The amount paid, often in monthly installments, for an insurance policy by the employer or patient themselves. In some states, if the patient is behind on their premium payment, State Law may allow the insurance company to take the claim payment and apply it to the premium owed.

Prevailing Charge – This is an amount that an insurance company says it pays for some services and is a clause placed in some provider contracts. The prevailing charge is developed by the insurance company when the payment to the provider is based on the Medicare allowable. The contract usually says, If there is a service that has no RBRVS, then the service will be paid at the prevailing charge fee.

When an insurance company mentions prevailing charge needs to be clearly addressed. I've seen some prevailing charges to be based on 10 year old Medicare allowables.

PCP (Primary Care Provider):

The provider that is contracted with a health insurance company and whom the HMO, PPO, or POS patient selects as the medical provider that manages their healthcare. Under many patient health care benefit policies, the PCP is in charge of providing authorization for the patient to seek care from an out of network provider. The following is from a major insurance company patient health benefit manual:

*As a participant in the Plan, you will become a partner with your participating Primary Care Physician in preventive medicine. Consult your Primary Care Physician whenever you have questions about your health. Your Primary Care Physician will provide your care and will refer you to specialists or facilities for treatment when medically necessary. The referral is important because it is how your Primary Care Physician arranges for you to receive necessary, appropriate care and follow-up treatment. **You must have a prior written or electronic referral from your Primary Care Physician.** Except for PCP, direct access, routine services and emergencies, you must have a prior written or electronic referral from your Primary Care Physician. Participating specialists are required to send reports back to your Primary Care Physician to keep your Primary Care Physician informed of any treatment plans ordered by the specialist.*

RA (Remittance Advice)

A Summarized statement that includes payment information for one or more beneficiaries or patients. An RA is similar to an EOB. The biller should make sure that the total payments on the RA match the amount on the check.

RBRVS (Resource-Based Relative Value Scale):

The Medicare RBRVS physician fee schedule replaced the Medicare physician payment system of “customary, prevailing, and reasonable” (CPR) or Usual, Customary and reasonable (UCR) charges under which physicians were paid according to the historical record of the charge for the provision of each service. The Relative Value Update Committee (the RUC), determines the Resource Based Relative Value for each new CPT code and revalues all existing codes at least once every five years. The RUC has 29 members, 23 of whom are appointed by major national medical societies. The six remaining seats are held by the Chair (an AMA appointee), an AMA representative, a representative from the CPT Editorial Panel,

a representative from the American Osteopathic Association, a representative from the Health Care Professions Advisory Committee and a representative from the Practice Expense Review Committee. The RBRVS for each CPT code is determined using three separate factors: physician work, practice expense, and malpractice expense. The RUC examines each new code to determine a relative value by comparing the physician work of the new code to the physician work involved in existing codes.

Reasonable and Customary (R & C) – a term used by an insurance company to refer to what the insurance company says are the provider charges or the insurance company prevailing fees for health services within a geographic area. Also known as UCR: Usual, Customary and Reasonable.

Secondary Insurance – A health insurance policy that a patient obtains through payment or through a Government Plan such as Medicare, Medicaid or Tricare in order to help defray additional health care costs that a primary insurance or Medicare may not pay for such as deductibles, or provides additional health care benefits. A patient may have Blue Cross as a Primary Insurance and Medicare as secondary insurance or coverage. A patient may have Medicare Part B as primary and Medicaid or Tricare as secondary insurance. How the secondary insurance pays is based on their internal rules or per a provider contract. Providers who have no contract with the patient's commercial secondary insurance may have a policy that requires the patient to submit their own claim to their own insurance company. Medicare and Medicaid mandates that the provider submits the claim for the patient or member.

SNF (Skilled Nursing Facility) – a facility, either free-standing or part of a hospital, that accepts patients seeking rehabilitation and medical care that is less intense than that received in a hospital.

Statement:

A bill detailing the service received by the patient. Some statements may contain the date of service, CPT Code, the charges, any payments, adjustments, current balance and possible aging of the debt. Some states have laws regulating statements. Some practices do not believe in sending statements to patients. In Florida, under the Patient Rights law, the patient is entitled to receive a statement if requested. The patient also has a right to know all charges and costs associated with the visit. Some people will say you are mandated to send three statements and a final notice letter before you send the patient to a debt collection agency.

This has never been proven by those making that claim. I have never seen this requirement in any State or Federal law.

Self Pay:

A term to mean that the patient owes the medical bill. I use Self pay with patients who have insurance. The insurance has paid its portion or denied the claim and the appeal is unwinnable, the responsibility for payment is transferred to the patient. Patients who owe the medical debt who had no insurance coverage, I call uninsured. I separate the two as a means of monitoring receivables. I can run a self pay account to show how many patients with insurance owe the doctor. I can also review these accounts before sending the account to a debt collection agency so that an unpaid claim is sent mistakenly to the collection agency due to a glitch in the medical billing software or due to someone's mistake in converting the account from insurance responsibility to patient responsibility.

Self-insured plan:

A plan offered by employers who directly assume the major cost of health insurance for their employees. This can include regular health insurance or workers compensation coverage that is approved by the State Workers Compensation regulatory authority. The claims process, benefit payment and appeals process for regular health insurance through self-insured plans may come under the jurisdiction of ERISA. See 29 CFR 2560-503-1.

TPA (Third Party Administrator)

An individual or company hired by an employer or insurance company to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. For example, Aetna may hire ABC Company to review, process, suggest claims payment amounts for all of Aetna's claims or even issue checks on behalf of Aetna. The check you receive may come from ABC Company. You may end up calling ABC to find out who the parent insurance company would be. You would also closely scrutinize the payment for accuracy. ABC Company would be the TPA for Aetna.

(UCR) Usual, Customary and Reasonable :

A health insurance term to define how an insurance company pays for a claim for health benefits. This can vary per insurance company. Some may state that UCR is based on how much providers of the same specialty in the same geographical area charge for a specific service. How the insurance company determines this is

unknown and known only to the insurance company. The UCR may be all that the insurance company is required to pay per their contract with the member. The non-par provider does not have to accept the UCR payment as payment in full unless State law prohibits patient balance billing, but check with the patient's benefit manual to see if the patient is required to pay anything above UCR.

WC (Workers Compensation)

This is healthcare coverage that is mandated by State Law, to be provided to an employee in the event of work related injuries and illnesses. Each State has its own laws and regulations on managing workers compensation. Some employers may be exempt from providing workers compensation insurance. Payment of claims could be based on a State established fee schedule. The payment could be required to be accepted as payment in full. Some states may have HMO requirements that require the employee to seek care at the HMO and if the employee goes outside the HMO without approval, the claim could be denied with the employee responsible to pay the medical bill. The employee's injury could also be investigated by the employer or workers compensation insurance company to determine if the injury is valid. If found invalid, this too could require the employee to pay for the medical care. Examples of an invalid injury is when the employee is drunk or on drugs or started a fight at work.