Med 137 Word list

Chapters 17, 18, and 19

CHAPTER 17

Abuse: Misuse; excessive or improper use, especially of narcotics or psychoactive drugs.

Adjustment: Increases or decreases to patient accounts not due to charges incurred or payments received.

Assignment of Benefits: Signing over of benefits by the beneficiary to another party.

Beneficiary: Person under a policy eligible to receive benefits.

Benefit Period: The specified time during which benefits will be paid under certain types of health insurance coverage.

Birthday rule: Method to determine which of two or more policies covering a dependent child will be primary; the parent with the birthday falling first in the calendar year has the primary policy.

Capitation: Use of the number of members enrolled in a plan to determine salary of the provider; the provider is paid a fixed fee for each member no matter how many times that member is seen by the provider.

Centers for Medicare & Medicaid Services (CMS): Formerly known as HCFA. CMS is a federal agency within the U.S. Department of Health and Human Services (DHHS). The agency administers Medicare, Medicaid, and the State Children’s Health Insurance Program (SCHIP). CMS also administers the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Clinical Laboratory Improvement Act of 1988 (CLIA ’88).

Coinsurance: That percentage paid by the company or that paid by the insured.

Coordination of Benefits (COB): The provision of an insurance contract that limits benefits to 100% of the cost.

Co-payment: Payment required when seen by the provider.

Deductible: That amount of incurred medical expenses that must be met before the insurance policy will begin to pay.

Defense Enrollment Eligible Reporting System (DEERS): A system operated by the Department of Defense and used by TRICARE contractors to determine and confirm the eligibility of beneficiaries.

Donut Hole: Within the Medicare Part D prescription drug program, the donut hole is the phase of coverage in which all costs are covered by the enrollee rather than CMS.

Exclusion: Specific disease or condition listed in an insurance policy for which the policy will not pay.

Exclusive Provider Organization (EPO): A closed-panel preferred organization (PPO) plan where enrollees receive no benefits if they opt to receive care from a provider who is not in the EPO.

Explanation of Benefits (EBO): Insurance report that is sent with claim payments explaining the reimbursement of the insurance carrier.

Fiscal Intermediary: Local administrator for Medicare.

Fraud: Deliberate misrepresentation of facts.

Health Maintenance Organization (HMO): Type of managed care operation that is typically set up as a for-profit corporation with salaried employees. HMO’s “with walls” offer a range of medical services under one roof; HMO’s “without walls” typically contract with providers in the community to provide patient services for an agreed-upon fee.

Integrated Delivery System (IDS): A health care organization of affiliated provider sites combined under a single ownership that offers the full spectrum of managed health care.

Managed Care Organization (MCO): A health insurance organization that adheres to the principles of strong dependence on selective contracting with providers: the use of primary care physicians, prospective and retrospective utilization management, use of treatment guidelines for high cost chronic disorders, and an emphasis on preventive care, education, and patient compliance with treatment plans.

Medicare Part A: Benefits covering inpatient hospital and skilled nursing facilities, hospice care, and blood transfusion.

Medicare Part B: Benefits covering outpatient hospital and health care provider services.

Medicare Part C: Commonly referred to as Medicare advantage plans. These plans are approved by Medicare and are run by private companies.

Medicare Part D: Prescription drug coverage by Medicare.

Medigap Policy: An individual plan covering the patient’s Medicare deductible and co-pay obligations that fulfills the federal government standards for Medicare supplemental insurance.

Point-of-Service Plan (POS): A plan that allows direct communication between a medical office and the health insurance company.

Preauthorization: Obtaining and insurance carrier’s consent to proceed with patient care and treatment. Unless authorization is obtained, insurance carriers may not pay benefits for specific problems.

Preferred Provider Organization (PPO): Organization of providers who network together to offer discounts to purchasers of health care insurance.

Primary Care Provider (PCP): Primary care physician for a patient; all care is coordinated through the PCP.

Referral: Term used by managed care facilities for authorization for someone other than the patient’s primary care provider to treat the patient.

Remittance Advice (Remit): The providers remit summarizes all of the benefits paid to the provider within a particular period of time. The remit includes all of the patients covered by a specific insurance for that time period.

Resource-Based Relative Value Scale (RBRVS): Basis for the Medicare fee schedule.

Self-Insurance: Insurance carried by large companies, nonprofit organizations, and government to reduce costs and gain more control of their finances. Each plan differs in coverage and claim filing requirements.

TRICARE: Formerly the Civilian Health and Medical Program for Uniformed Services (CHAMPUS). TRICARE offers HMO, PPO, and fee-for-service medical insurance for dependents of active duty and retired military personnel and dependents of personnel who died while on active duty.

Triple Option Plan: A managed care model allowing enrollees the option of traditional, HMO, or PPO health plans.

Usual, Customary, and Reasonable (UCR): Fee schedule often used by Medicare and some insurance carriers. Usual refers to the fee typically charged by a provider for certain procedures; customary is based on the average charge for a specific procedure by all providers practicing the same specialty in a defined geographic region; and reasonable refers to the midrange of fees charged for this procedure.

Worker’s Compensation Insurance: Medical and paycheck insurance for workers who sustain injuries associated with their employment.

CHAPTER 18

Bundled Codes: A grouping of several services that are directly related to a specific procedure and are paid as one.

Claim Register: Diary or register of claims submitted to each insurance carrier. When payment is received, the date and amount of payment is entered in the register.

CMS-1500 (08-05): Formerly known as the HCFA 1500 form that is the office health insurance claim form for Medicare and Medicaid.

Current Procedural Terminology (CPT): Standard codes for procedures and services. Used by most ambulatory care settings in encoding the claim form and recognized by most insurance carriers.

Down-coding: Insurance carriers down-code if documentation or codes are ambiguous and reimburse for the lowest possible fee.

E Codes: ICD-9-CM codes for the external causes of injury, poisoning, or other adverse reactions that explain how the injury occurred.

Encounter Form: Formerly known as a charge slip or superbill. A copy of the encounter form is given to the patient after seeing the provider. It identifies the procedure performed, diagnoses, charges, and when to return.

Explanation of Benefits (EOB): Insurance report that is sent with claim payments explaining the reimbursement of the insurance carrier.

Healthcare Common Procedure Coding System (HCPCS): A coding system consisting of the CPT, national codes (level II), and local codes (level III); previously known as HCFA Common Procedure Coding System.

International Classification of Diseases, 9th Revision Clinical Modification (ICD-9-CM): Standard diagnosis codes used to identify a patient’s medical problem. Used by most ambulatory care settings in encoding the claim form and recognized by most insurance carriers.

M Codes: Found in the ICD-9-CM and used primarily with cancer registries. M codes further identify behavior and the cell type of a neoplasm.

Modifier: An additional code that may be added to a five-digit CPT code to further explain the service provided.

Point-of-Service Device (POS): Device allowing direct communication between a medical office and the health care plan’s computer.

Unbundling Codes: Refers to separating the components of a procedure and reporting them as billable codes with charges to increase reimbursement rates.

Uniform Bill 04 (UB-04): Unique billing form used extensively by acute care facilities for processing inpatient and outpatient claims.

Up-coding: Also known as code creep, over coding, and overbilling. Up-coding occurs when the insurance carrier deliberately bills a higher rate service than what was performed to obtain greater reimbursement.

V codes: ICD-9-CM codes representing either factor that influence a person’s health status or legitimate reasons for contacting the health facility when the patient has no definite diagnosis or active symptom of any disorder.

CHAPTER 19

Accounts Payable: Sum owed by a business for services or goods received; also unwritten promise to pay a supplier for property or merchandise purchased on credit or for service rendered.

Accounts Receivable: Amount owed to a business for services or goods supplied.

Adjustments: Increases or decreases to patient accounts not due to charges incurred or payments received.

Balance: Amount owed (N); to verify posting accuracy (V); records difference between debit and credit columns.

Cashier’s Check: Bank’s own check drawn against the bank’s account.

Certified Check: Depositor’s own check that the bank has indicated with a date and signature to be good for the amount written.

Credit: Decreases balance due; column used for entering payments.

Day Sheet: Form used with pegboard system to record daily patient transactions.

Debit: Used for entering charges and description of services; column is on the left.

Encounter Form: See Chapter 18

Guarantor: The person identified as responsible for payment of the bill.

Ledger: Record of charges, payments, and adjustments for individual patient or family.

Money Market Account: Bank accounts that pay a higher interest rate than standard savings accounts and permit writing a limited number of checks.

Notary: Someone with the legal capacity to witness and certify documents; can take depositions.

Payee: Person named on check who is to receive the amount indicated.

Pegboard System: Most commonly used manual medical accounts receivable system.

Petty Cash: Small sum kept on hand for minor or unexpected expenses.

Posting: Recording financial transactions into a book keeping or accounting system.

Traveler’s Check: Often used in place of cash when traveling; available in denominations of $20 to $100; requires a signature at place of purchase as well as signature at the time the check is used.

Voucher Check: Check with detachable form used to detail reason check is drawn; commonly used in payroll checks.