COMMONLY USED TERMS

Below are commonly used terms within the STD Billing Toolkit

ACA Marketplace: A health insurance exchange where individual and family insurance plans can purchase health insurance plans at healthcare.gov. Note: California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New York, Rhode Island, Vermont and Washington have state marketplaces. More information here.

Affordable Care Act (ACA): Comprehensive healthcare reform signed into law in March of 2010 that expanded Medicaid eligibility, created health insurance exchanges and requires plans to cover a list of essential health benefits (Recommended Preventative Services).

Ancillary provider/Facility: Lab, x-ray facility, physical therapist.

Children's Health Insurance Program (CHIP): A program that provides low-cost healthcare coverage to children in families that earn too much money to qualify for Medicaid. Each state offers CHIP coverage and works closely with its state Medicaid program. In some states, CHIP covers pregnant women. More information here.

Claim: A written bill for services, submitted by a patient or on behalf of a patient to the patient's health insurance carrier for payment, per the terms of the patient's health insurance plan.

Claims Management Process: Preparation, submission, and collection of health care claims.

Clearinghouse: A private company that serves to transmit and translate claim information from a health care provider or other billing entity to the third-party payers in the format required by the payer.

Clearinghouse: Not be confused with an outsourced billing agency, a clearinghouse is a company that accepts electronic claims from a medical group's practice management software (PMS). The clearinghouse "scrubs" the claim with software that identifies obvious data entry errors and possible reasons for rejections. For example, if the date of birth is missing on the claim, the clearinghouse will flag the claim as incomplete and sends it back to the clinic. It then puts the claims in a universal format and sends them electronically to the insurance companies for processing.

Co-insurance: The amount paid by your benefits.

Commercial insurance: Also referred to as "private" insurance, a form of health insurance that is paid for by somebody other than the government. It may be paid for by the policyholder and/or by the policyholder's employer.

Contracting: The process of developing an agreement between a health care provider and a third-party payer that allows the provider recognized as an in- network provider.

Contractual Allowance: The difference between what an insurance company approves according to their contract and what the healthcare provider charges for the procedure. If the provider is under contract to accept the patient's insurance plan, the patient is generally not responsible for this difference. A contractual allowance shows up on a billing statement as an adjustment required and decreases the balance.

Co-payments: The portion of the total amount billed for services that the patient is responsible for paying as determined by the terms of the patient's health insurance policy.

Credentialing: The process of establishing the qualifications of a health care provider with the health insurance provider.

Deductible: The amount you pay before the insurance starts to pay.

Electronic Behavioral Health Record (EbHR): Just the same as the EHR (below), but for behavioral health information.

Electronic Health Records (EHR): Computer-based systems for managing medical and/or billing information for patients.

Electronic Medical Record (EMR): An individual's electronic record of health-related information. Authorized staff and clinicians within one healthcare organization can use the information.

Electronic Practice Management (EPM): The part of the electronic health system that contains financial, demographic, and other non-medical information. Other terms used for this information include Enterprise Management System and Practice Management System.

Encounter form: Also referred to as a "superbill," this form is particular to each clinic and is designed to capture the diagnostic and procedural codes most frequently used in that clinic.

Explanation of Benefits (EOB): A document outlining details about a processed medical insurance claim that explains what portion was paid to the healthcare provider and what portion, if any, is the patient's responsibility

Fee Schedules: The list of CPT codes and the amount the insurance company will pay under your contract.

First-Party Billing: A clinic or healthcare organization collecting payments from patients.

Formulary: The list of covered drugs.

Health Information Exchange (HIE): An electronic place for healthcare information from organizations within a community or region.

Health Information Technology (HIT): Electronic environment or platform which enables the exchange or storage of health-related information.

Healthcare Effectiveness Data and Information Set (HEDIS): A set of measures used by more than 90 percent of health insurance providers to gauge their performance on dimensions of care and service.

In-house: Staff of a clinic or health department are responsible for all aspects of revenue cycle management. They submit claims to a clearinghouse, directly to Medicaid, or to the insurance company for reimbursement. They also set charges, collect patient fees (copays and deductibles), and manage the accounts receivable.

Interoperability: The ability of software and hardware on multiple pieces of equipment made by different companies to communicate and work together.

Medicaid: A state and federal public health insurance program that provides coverage to low-income families or individuals.

Medicaid Managed Care Organization: An agency which supports delivery of Medicaid health benefits to clients, through an agreement with a state Medicaid agency.

Medical Case Management (MCM): client-centered services that implement the clinical treatment plan including linkage to health care, psychosocial and other services that are provided under the direction of or by referral from a clinical provider; a core Ryan White service.

Medical Home: Also known as “patient centered medical home; this is a model for comprehensive health care delivery that facilitates treatment through a patient’s primary care provider.

Medicare: A federal program that provides healthcare coverage to individuals 65 years of age and older or under 65 if one has a disability.

Member: Customer, individual, patient, you.

Memorandum of Agreement: A formal business document that outlines an agreement made between two entities or organizations

Mid-level provider: Health care providers, such as a Nurse Practitioner or Physician Assistant, who are licensed to diagnose and treat patients under the supervision of a physician.

National Provider Identifier (NPI): Avunique, 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).

Out-of Network Provider: A provider or facility that does not have a contract with the patient’s insurance company.

Outsourced Billing: Providers may outsource their medical billing to a third party known as a medical billing service. These billing services typically take a percentage of a practice's collections as payment for managing many aspects of a clinic’s revenue cycle. There may be recurring monthly fees as well.

Paid claims: A bill that has been submitted to a health insurance provider and payment has been made.

Payer mix: The relative proportion of clinic or provider revenue that comes from private insurance, government insurance (Medicaid and/or Medicare) and self-paying individuals).

Pending claims: Bills for services rendered that have been submitted to a health insurance provider for payment but have not yet been processed.

PrEP: Pre-Exposure Prophylaxis; a highly effective once per day medication to prevent HIV infection. More information here.

Provider: Doctor, hospital, nurse, healthcare professional.

Public Insurance: A form of health insurance that is paid for by the government, including Medicaid and Medicare.

Recommended Preventative Services: preventative services required by the US Preventative Ser ices Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP) and the Health Resources and Services Administration (HRSA) that are required to be available without patient cost-sharing. An updated list of such services can be found here.

Remittance: Payment from a health insurance provider to the health care provider who submitted the claim.

Revenue Cycle: The entire life of a patient account from creation to payment, including all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.

State-based exchanges: Mechanism to facilitate access to state regulated and standardized health insurance plans as mandated by the Patient Protection and Affordable Care Act.

Submitted Charges: The amount you bill to the insurance company.

Superbill: Also referred to as an “encounter form” this form is particular to each clinic captures the diagnostic and procedural codes most frequently used in that clinic.

Third-Party Billing: A public or private entity or program that is responsible for paying all or part of the expenses for medical care per the terms of the health insurance policy of the policyholder. A third-party payer neither receives nor administers medical care.

Third-Party Payer: A public or private entity or program that is responsible for paying all or part of the expenses for medical care per the terms of the health insurance policy of the policyholder. A third-party payer neither receives nor administers medical care.

Title X Family Planning Program: a federal grant program created to provide comprehensive and confidential family planning and preventive health services including

contraception counseling and provision, breast, and cervical cancer screenings, testing and treatment for STDs and pregnancy diagnosis and counseling.