Glossary of Billing-Related Terms for Human Immunodeficiency Virus, Sexually Transmitted Infections, and Viral Hepatitis Preventive and Clinical Services

for Health Departments, Community-Based Organizations, and Healthcare Organizations

PROCEED INC

CHBT
Center for Health & Behavioral Training

PRIMARY CARE DEVELOPMENT CORPORATION

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BUILDING THE CAPACITY OF THE NATION'S HIV PREVENTION WORKFORCE

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INTRODUCTION TO THE GLOSSARY OF BILLING-RELATED TERMS

The passage of the Affordable Care Act significantly expanded medical insurance coverage to many Americans and has subsequently shifted the healthcare landscape and the way in which healthcare is accessed, delivered, and reimbursed. The provision of prevention, testing, care, treatment, and support services for human immunodeficiency virus (HIV), sexually transmitted infections (STI), and viral hepatitis (VH) has been similarly affected. These changes require those of us who are providers to expand our knowledge in healthcare financing, including medical billing and coding. In response to this need, PROCEED, Inc. - National Center for Training, Support, and Technical Assistance (NCTSTA); in collaboration with the University of Rochester Center for Health & Behavioral Training; and the Primary Care Development Corporation have collectively developed this Glossary of Billing-Related Terms as a web-based resource.

THE PURPOSE of this Glossary of Billing-Related Terms is to provide a user-friendly online tool that supports the orientation of HIV, STI, and VH prevention and treatment staff and other stakeholders around the language of healthcare billing.

UTILIZATION OF THE GLOSSARY OF BILLING-RELATED TERMS: This Glossary of Billing-Related Terms provides definitions and explanations for the most commonly used medical billing, healthcare finance, and third-party reimbursement terminology and acronyms. The Glossary of Billing-Related Terms is applicable across HIV, STI, and VH prevention and treatment-provider settings. Terms are organized alphabetically for easy reference.

THE INTENDED AUDIENCE for this Glossary of Billing-Related Terms includes administrators, healthcare staff, and billing office personnel of community-based organizations, healthcare organizations, health departments, and capacity building assistance provider organizations.

BILLING-RELATED TERMS

Accountable care organization (ACO)
A group of healthcare providers that offer coordinated care and support services for chronic-disease management with the aim of improving quality of care. Payments to providers are tied to achieving healthcare quality goals and outcomes that result in cost savings.

Ancillary provider/ facility
A healthcare provider or facility whose services include lab tests; radiology tests (X-rays); physical, speech, and occupational therapies; and ambulance services. Ancillary services support the diagnosis and treatment of a patient's condition.

Capitation
A fixed amount of money per patient per unit of time paid in advance to the healthcare provider for the delivery of healthcare services. Sometimes referred to as a "per capita rate."

Charge master
A comprehensive list of all services or supplies offered at a clinic or hospital, including the procedure code and price.

Children's Health Insurance Program (CHIP)
An insurance program, jointly funded by state and federal governments, that provides health coverage to low-income children. In some states, CHIP also provides coverage to pregnant women within families that earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

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

Claims management process
This process starts when a healthcare provider treats a patient and sends a bill of services to the patient's health insurance carrier. The process includes the preparation and submission of the bill to the insurance carrier, the insurer's generation of an explanation of benefits, and a payment to the healthcare provider, per the terms of the patient's health insurance plan. See also "explanation of benefits."

Clearinghouse
A company that transmits and translates claim information from a healthcare provider or other billing entity to the insurance carrier, in the format required by the insurer.

Center for Medicare and Medicaid Services (CMS)
The federal agency that administers Medicare services at the federal level and develops policy and recommendations for state-managed Medicaid services.

Coding
A method used by healthcare providers to classify and define services and supplies provided to patients into a set of predetermined numbers (codes) for the purpose of billing.

Coding of claims
A process through which procedures, services, and diagnoses from the patient's medical record are translated into numbers (codes) that can be processed for payment.

Coding specialist
A person who has completed specialized training in how to select the codes described above (see "Coding" and "Coding of claims"). This training is ongoing, as the codes and the procedures for billing are frequently changed by Medicare, Medicaid, and other third-party payers.

Co-insurance
An arrangement in which patients and their insurance company share payment for a healthcare service. Co-insurance takes effect after the deductible amount has been paid. It is usually a percentage of the cost of medical services (e.g., patient pays 20%, insurance plan pays 80%) until the patient's annual maximum out-of-pocket expense is reached.

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 healthcare provider and a third-party payer (such as an insurance company) that allows the provider to be recognized as an in-network provider and to be reimbursed for claims.

Contractual allowance
The difference between what an insurance company approves according to their contract and what the healthcare provider charges for the procedure. Also referred to as "contractual adjustment." 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 and decreases the balance.

Co-payments
The fixed amount set by an insurance company and paid by a patient for a specified medical service. A co-payment is often connected with a physician-office visit or an emergency-room visit. Co-payments are collected at the time services are provided and the amount determined by the terms of the patient's health insurance policy.

Current Procedural Terminology (CPT) codes
A listing of standardized descriptions and five-character alphanumeric codes used by medical coders and billers to report healthcare services and procedures to payers for reimbursement. See also “Evaluation and management coding” and “Modifier codes.”

Credentialing
The process of establishing the qualifications of a healthcare provider by the health insurance company. Usually a healthcare provider has to be credentialed by each third-party payer. Most insurers require their providers to submit annual updates of their credentials.

Deductible
The amount the patient pays (out-of-pocket) before the insurance starts to pay. This amount varies by insurance plan.

Denial
A claim that is not paid by an insurance carrier. Denials can be made for many reasons: non-credentialed provider, client not insured on date of service, service not covered, prior authorization needed but not on claim, etc. Denials can often be appealed under the terms of the agency’s contract.

Donut hole
Also referred to as a coverage gap. The donut hole begins after a patient and his/her drug plan have spent a certain amount of money in a specific year for covered drugs ($3,310 for those on Medicare in 2016). The patient is then required to pay 45% of their plan’s cost for covered brand-name prescription drugs. Most of this payment will count toward the patient’s out-of-pocket cost. Once the patient has spent the annual maximum out-of-pocket, his/her coverage gap ends, and the drug plan helps pay for covered drugs again. Most plans with Medicare prescription-drug coverage have a donut hole.

Essential health benefits
A set of benefits in 10 categories of healthcare services, set by the Secretary of Health and Human Services, that healthcare coverage plans are required to offer under the Affordable Care Act. These 10 categories are as follows:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental-health and substance-use-disorder services, including behavioral-health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services and chronic-disease management/
- Pediatric services, up to age 19, including oral and vision care.

Evaluation and management (E & M) coding

The process by which physician-patient encounters are translated into five-digit CPT codes to facilitate billing. These codes document the complexity of the patient's history, physical exam, and medical decision-making. The following elements are used by a clinician to select an E & M code when billing for a patient visit:

- **Body areas/organ systems (BA/OS)** — these indicate which parts of the body were examined.
- **History of present illness (HPI)** — a history of the problem for which the patient is being seen.
- **Medical decision making (MDM)** — the medical complexity of the visit.
- **Past medical family social history (PFSH)** — a history of past medical problems, family history, and history of patient's drug/alcohol use, sexual history, etc.
- **Physical examination (PE)** — an evaluation of the body and its functions by means of sight, touch, percussion, or auscultation (listening) to diagnose disease or verify fitness.
- **Review of systems (ROS)** — a review of the range of symptoms the patient may be having on the day of visit.

See also "Current Procedural Terminology (CPT) Codes."

Explanation of benefits (EOB)/ Explanation of member benefits (EOMB)

The statement sent by the insurance company to the patient with a list of services received by the patient, amount billed, and any insurance payments. This statement normally includes any payment due from the patient, such as co-insurance, deductibles, and co-payments.

Fee schedules

The list of CPT codes and the amount the insurance company will pay under a patient's contract. Fee schedules often vary by provider type.

Fee-for-service (FFS)

A type of reimbursement in which insurance companies pay for each service provided based on set rates for each type of service.

Federally qualified health centers (FQHC)

Federally designated and funded nonprofit health centers or clinics that serve medically underserved areas and populations. FQHCs provide primary care services regardless of a patient's ability to pay. Services are provided on a sliding-scale fee based on patient's ability to pay. Medicaid rates for FQHCs are set federally, based on annual cost reports and are generally higher than state-set Medicaid clinic/health center rates.

Federally qualified health center (look-alike)

A health center that complies with all requirements to become an FQHC but does not receive federal funding from the Section 330 funding reserved for FQHCs. Look-alikes are allowed to purchase prescription drugs and devices at reduced cost through the 340B program and receive the same enhanced reimbursement rate afforded to FQHCs.

Formulary
A list of prescription drugs and costs for which an insurance company will provide reimbursement.

Health Common Procedure Coding System (HCPCS) codes
A coding system used to describe outpatient services provided to the patient. HCPCS codes are used by Medicare; some of these codes are also used by Medicaid and third-party insurance claims.

Healthcare Effectiveness Data and Information Set (HEDIS)
A set of measures developed by the National Committee for Quality Assurance and used by more than 90 percent of health insurance providers to gauge their performance on dimensions of care and service.

Health home
A federally defined term for a care-coordination structure for chronically ill Medicare/Medicaid beneficiaries that identifies one of the multiple organizations caring for those individuals as their "health home" and provides reimbursement to that organization for case-management services intended to improve the patient's health and reduce costs.

Health information technology (HIT)
An umbrella term covering any technology that improves the collection and sharing of health information among doctors, patients, hospitals, insurers, and other stakeholders in the healthcare system. HIT includes:

- **Electronic behavioral health record (EBHR)** — a digital version of the behavioral health paper chart, which would typically include therapy notes, diagnosis, progress, treatment plan, discharge notes, notes review, co-signature, forms, and billing features over time.
- **Electronic health record (EHR) or electronic medical record (EMR)** — a digital version of the paper chart. They include medical and treatment history of a patient over time. The two terms are used interchangeably, but many government offices prefer "EHR," as the term "health" is more inclusive than the word "medical." As such, the EHR suggests a record that goes beyond the standard clinical data collected in a single provider's office to include information from all of the clinicians involved in a patient's care.
- **Health information exchange (HIE)** — the provision of healthcare information electronically across organizations within a region, community, or hospital system.
- **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."

Health Insurance Portability and Accountability Act (HIPAA)
This federal act sets standards for securing and protecting the privacy of patient/client health information. Patients are required to sign a form attesting that they have been made aware of HIPAA protections (Notice of Privacy).

International Classification of Diseases (ICD)

An international, standard diagnostic tool for epidemiology, health management, and clinical purposes. The ICD is a coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. The ICD is copyrighted by the World Health Organization, which owns and publishes the classification. In comparison, the CPT codes are used to report and describe medical procedures and services conducted by healthcare providers. The CPT codes outline exactly what was done to a patient during a consultation, whereas the ICD codes describe a disease and identify the diagnosis of a particular medical condition. See also "Current Procedural Terminology" codes and "Evaluation and management coding."

International Statistical Classification of Diseases (ICD-10)

A code set that replaced ICD-9 to report medical diagnoses on claims as of October 1, 2015. The ICD-10 is more complex and longer than the ICD-9 version. The ICD-10 allows more than 14,400 different codes and permits the tracking of many new diagnoses. Using optional sub-classifications, the codes can be expanded to more than 16,000 codes. ICD-10-CM refers to a clinical modification of the ICD-10, usually to assure clinical accuracy and utility. See also "International Classification of Diseases."

Managed care

A system of healthcare in which patients agree to visit only certain doctors and hospitals, and in which the cost of treatment is monitored by a managing organization such as a Health Maintenance Organization (HMO) or other type of insurance company. In managed care plans, providers are paid a flat rate per person/year regardless of the number of services provided. The growth of managed care was spurred by the enactment of the Health Maintenance Organization Act of 1973 with the intention of reducing unnecessary healthcare costs.

Medicaid

A publicly financed insurance program for low-income individuals or families. Although financed by federal, state, and local funds, it is managed by the state. As such, there is a great deal of variation, from state to state, in who is covered and what services are covered. Medicaid insurance plans may be fee-for-service or managed care.

Medicaid managed care

A managed care network in which private insurance companies contract with a state Medicaid program to provide Medicaid services to enrollees and are paid a capitated, annual amount for each enrollee.

Medicare

A federal insurance plan that covers persons ages 65 and older and some younger persons who receive SSI (Supplemental Security Income) benefits. Medicare is a single-payer system managed by the federal government and paid for with federal tax dollars. Medicare benefits are standardized and do not vary state to state.

Medicare cont.

- **Medicare Part A** — Medicare coverage that helps pay for inpatient hospital, home health, hospice, and skilled nursing facility services.
- **Medicare Part B** — Medicare coverage that helps pay for physician services, medical supplies, and other outpatient services not paid for by Medicare Part A.
- **Medicare Part D** — Medicare coverage that helps pay for the costs of prescription drugs.

Modifier codes

Also referred to as CPT modifiers; codes that may be added to a CPT code on a claim to detail additional or specific services that were provided. For example, the modifier for preventive services is 33 and must be added to show that no co-pay was charged for preventive services. Lack of accurate modifiers is a common reason claims are denied.

Nucleic acid amplification testing (NAAT)

Tests that detect the genetic material of a bacterium or virus, in part by amplifying or making numerous copies of that genetic material, thus shortening the window period (the period of time between infection and when a test is positive). This type of test is the most likely (sensitive) to detect gonorrhea, chlamydia, and other infections. NAATs are now replacing other types of tests as the “gold standard” (most accurate) for detecting infections. The HIV viral load, PCR, and RNA tests are all NAATs.
NAAT can be conducted on urethral, cervical, vaginal, or rectal swabs, as well as urine for chlamydia and gonorrhea. Blood samples are typically used for HIV NAAT.

Over-the-counter drugs (OTC)

Drugs that may be purchased at a pharmacy or drug store without prescription.

Out-of-network provider

A provider that is outside the network of doctors, hospitals, or other healthcare providers that the insurance company has contracted with to give care. This term usually applies to Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). A patient who uses an out-of-network provider is typically responsible for a greater portion of the charges or may have to pay all the charges for using an out-of-network provider.

Paid claims

A bill/claim that has been submitted to a health insurance provider and for which payment has been made.

Payer mix

The sources of revenue — including commercial insurance, public insurance, and self-paying patients — in a healthcare provider setting.

Pending claims

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

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

Remittance advice
A document supplied by the insurance payer with information on claims submitted for payment. Contains explanations for rejected or denied claims. Also referred to as an "EOB" (Explanation of Benefits). See also "Explanation of benefits."

State-based exchanges
The mechanism to facilitate access to state-regulated and -standardized health insurance plans as mandated by the Affordable Care Act. Also referred to as "insurance marketplaces." Individuals, families, and small business are able to buy qualified health plans through their state's state-based marketplace or a state partnership marketplace (set up by a state in partnership with the federal marketplace, but tailored to the needs of beneficiaries and market conditions in that state).

Submitted charges
The amount the healthcare provider bills the insurance company for a specific service.

Superbill
Also referred to as a "patient encounter form"; a form, specific to a healthcare facility, that lists the rendered services provided to a patient. The superbill is the main data source for creation of healthcare claims.

Third-party payers
An organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries, such as commercial insurance companies, Medicare, and Medicaid. An employer or individual generally pays a premium for coverage in all such private and in some public programs. The organization then pays bills on the beneficiary's behalf.

Utilization review (UR)
A formal assessment of the medical necessity, efficiency, and/or appropriateness of healthcare services provided to the patient.

Z codes
ICD-10 codes used to identify the reasons for an encounter when a patient presents to a healthcare facility for reasons other than a disease or injury (e.g., body mass index screening, genetic testing, prevention counseling, or reproduction counseling).

REFERENCES

This glossary was compiled from the following sources:

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ADDITIONAL RESOURCES

Resources for additional information on healthcare billing and financing:

- Advancing the Business of Healthcare — Medical billing
- American Medical Association — CPT coding, billing, and insurance
- Centers for Medicare and Medicaid Services
- HealthCare.gov
- HealthIT.gov
- Kaiser Family Foundation
- STD-Related Reproductive Health Training and Technical Assistance Center (STD-TAC) — Billing toolkit
- Health Services and Resources Administration

For additional information on CDC's Capacity Building Assistance program, please visit the Capacity Building Assistance (CBA) Provider Network at: http://www.cbaproviders.org/