

I. Glossary

A

Account or Account Number - The number assigned by the hospital's health information system at the time of each of your medical visits.

Actual Charge - The amount of money associated with the provision of your care.

Adjustment Amount - This is the difference between what your insurance company will pay for your services including any patient deductible or coinsurance amounts due from the patient and the actual charges. **Admission Date (Admit Date)** - Date you were admitted for treatment.

Admission Hour - The hour that you were admitted for inpatient or outpatient care.

Registration Diagnosis - Words that you or your physician uses to describe your condition

Advance Beneficiary Notice (ABN) - A notice the hospital or physician gives you before you're treated, telling you that insurance will not pay for some treatment or services. The notice is given to you so that you may decide whether or not to have the treatment and why you would be responsible for payment of the services. **Advance**

Directive (Health care) - Written ahead of time, a health care advance directive is a written document that says how you want medical decisions to be made if you lose the ability to make decisions for yourself. A health care advance directive may include a Living Will and a Durable Power of Attorney for health care.*

Ambulatory Payment Classifications (APC) - A Medicare payment system that classifies outpatient services so Medicare can pay all hospitals in a uniform manner for the same services.

Ambulatory Care - All types of health services that do not require an overnight hospital stay.*

Ambulatory Surgery - Outpatient surgery or surgery that does not require an overnight hospital stay.

Amount Charged - How much your physician or hospital bills you.

Amount Paid - The dollar amount that you or your insurance paid for your physician or hospital visit.

Amount Not Covered - What your insurance company does not pay. It includes deductibles, coinsurances, co-pays and charges for non-covered services.

Amount Payable by Plan - How much your insurer pays for your treatment, minus any deductibles, coinsurance, co-pays or charges for non-covered services.

Ancillary Service - These are typically outpatient services such as laboratory tests, radiology, and other diagnostic services usually provided only at a hospital.

Anesthesia - Drugs given to you during surgery to eliminate or reduce surgical procedure pain.

Appeal - A process by which you, your physician, or your hospital can object to your health plan when you disagree with the health plan's decision to not pay for your care.

Applied to Deductible - That portion of your bill, as defined by your insurance company, that you owe your physician or hospital.

Assignment of Benefits - The agreement you or your insurance company signs that allows your insurance payments to be paid directly to your physician or the hospital.

Attending Physician Name - The physician who certifies that you need treatment and is responsible for your care.

Authorization Number - A number stating that your treatment has been approved by your insurance plan. Also called a certification number or prior-authorization number. The authorization does not guarantee coverage or payment for services.

B

Balance Bill - How much physicians and hospitals charge you after your health plan or insurance company have paid their approved amounts.

Beneficiary - Person covered by health insurance.

Beneficiary Eligibility Verification - A way for physicians and hospitals to get information about whether you have insurance coverage.

Benefit – Insurance coverage for specific services.

Bill/Invoice/Statement - Printed summary of your medical bill.

C

Cardiology Charges - Charges for heart procedures. Examples are heart catheterization and stress testing.

Case Management - Services provided by your insurance company or hospital nursing staff aimed at assuring you are getting the most clinically appropriate services in the right setting.

Centers for Medicare and Medicaid (CMS) - The federal agency that runs the Medicare and Medicaid programs. CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.*

CHAMPUS - The Insurance linked to past or present military service, also known as TriCare.

Claim - Your medical bill that is sent to an insurance company for processing.

Claim Number - A number given to a medical service.

Clean Claim - A claim that does not have to be investigated by insurance companies before they process it.

Clinic - An area in a hospital or separate building that treats regularly scheduled office visits, clinical treatment areas or walk-in patients services for non-emergency care.

CMS 1500 - A national standard form used by physicians to file insurance claims for professional services.

COBRA Insurance - The ability to extend your former employer health insurance program if you leave or change employment. The individual is responsible for the cost of this service but they can extend coverage up to 18 months.

Coding of Claims - The translation of your clinical encounter into uniform international set of diagnoses and procedures codes.

Coinsurance - The cost sharing part of your bill that you have to pay.

Coinsurance Days (Medicare) - Hospital Inpatient Medicare coverage from day 61 to day 90 of continuous hospitalization. You are responsible for paying for part of those days. After the 90th day, you enter your "Lifetime Reserve Days."

Collection Agency - The hospital's business partner that collects money for unpaid bad debt accounts. .

Consent (for treatment) - An agreement you sign that gives your permission to receive medical services or treatment from physicians or hospitals.

Contractual Adjustment - A part of your bill that your physician or hospital must adjust because of billing agreements with your insurance company.

Coordination of Benefits (COB) - The order of responsibility if you have more than one insurance plan for insurance company payments.

Co-payment - A cost sharing part of your bill that is your responsibility to pay. Also known as co-pay.

Covered Benefit - A health service or item that is included in your health plan.

Covered Days - Days that your insurance company pays for in full or in part.

CPT Codes - A national standard coding system used to describe what treatment or services were given to you by your physician or during an outpatient hospital visit.

CT Scan - A type of x-ray of the head or body, usually performed in a hospital's radiology department.

D

Date of Service (DOS) - The date(s) when you were treated.

Days - The total number of inpatient days that you are being charged for the hospital's services.

Deductible - An insurance cost sharing amount that you must pay for medical services before your insurance company will to pay

Description of Services – Describes the services you received by your physician or the hospital.

Diagnosis Code (International Classification of Diseases, 9th Edition (ICD-9-CM)) - A national standard code used for billing that describes your illness.

Diagnosis-Related Groups (DRGs) - A national standard coding system for inpatient hospital services. This system categorizes illnesses and medical procedures into groups for which hospitals are paid a fixed amount for each admission.

Discharge Hour - The hour that you were discharged.

Discount - A dollar amount taken off your bill, usually because of a contract with your hospital or physician and your insurance company or for prompt payment of self pay patients.

Drugs/Self Administered - Federal programs do not pay for oral medications (tablets, suppositories, insulin) provided in an outpatient setting. You will typically be billed for these items over and above any co-insurance or deductible amounts.

Due from Insurance - How much money is due from your insurance company.

Due from Patient - How much you owe your physician or hospital.

Durable Medical Equipment (DME) - Medical equipment that can be used many times, or special equipment ordered by your physician, usually for use at home.

E

EEG - Equipment or medical procedure that measures electricity in the brain.

EKG/ECG - Equipment or medical procedure that measures how your heart works, and your physician's reading of the results.

Eligible Payment Amount - Those medical services that an insurance company pays for.

Emergency Room - A department of a hospital that treats patients with emergency or urgent medical problems.

Estimated Insurance - Estimated cost paid by your insurance company.

Enrollee - A person who is covered by health insurance.

Estimated Amount Due - How much the physician or hospital estimates you or your insurance company owes.

Explanation of Benefits (EOB/EOMB) - The notice you receive from your insurance company after getting medical services from a physician or hospital. It tells you what was billed, the payment amount approved by your insurance, the amount paid, and what you are responsible for paying

F

Federal Tax ID Number - A number assigned by the federal government to physicians and hospitals, for tax purposes.

Financial Assistance - Free or reduced-fee care for patients who have financial hardships.

Financial Responsibility - How much of your bill you are responsible for paying.

Fiscal Intermediary (FI) - A Medicare agent that processes Medicare claims.

Fraud and Abuse - **Fraud:** To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. **Abuse:** Payment for items or services that are billed by mistake by providers, but should not be paid for by the insurance plan. This is not the same as fraud.*

G

Guarantor - Someone who has agreed to be financially responsible for paying the bill.

H

HBAS – Hospital Based Ambulatory Services – A hospital based outpatient physician office not located at the hospital.

HCPC Codes - A national standard coding system used to describe what treatment or services you received.

Healthcare Provider - Someone who provides medical services, such as physicians, nurse practitioners, physician assistants, midwifery etc.

Health Insurance - Coverage that provides medical/psychological benefits to insure your health and well being and/or pay for care.

HIPAA - Health Insurance Portability and Accountability Act. This federal act sets standards for protecting the privacy of your personal health information.

Home Health Agency - An agency that treats patients in their homes.

Hospice - Group that offers inpatient, outpatient, and home health care for terminally ill patients.

Hospital Inpatient Prospective Payment System (PPS) - A federal system that pays a fixed fee for inpatient care.

I

Insurance Company Name - Name of the company that your claim will be sent to.

Insured Group Name - Name of the group or insurance plan that insures you, usually an employer.

Insured Group Number - A number that your insurance company uses to identify the group under which you are insured.

Insured's Name (Beneficiary) - The name of the insured person.

Intensive Care - Medical or surgical care unit in a hospital that provides care for patients who need more care than a general medical or surgical unit can give.

Internal Control Number (ICN) - A number assigned to your bill by your insurance company or their agent.

IV Therapy - Treatment provided by giving intravenous solutions or drugs.

L

Labor and Delivery Room - A unit of a hospital where babies are born.

Lifetime Reserve Days (Medicare) - Under Medicare, you have a lifetime reserve of 60 more days of inpatient services after you use the first 90 benefit days. You must pay a fixed amount for each day of service.

Long-Term Care - Care received in a nursing home. Medicare does not pay for long-term care unless you need skilled nursing or special rehabilitation.

M

Managed Care - An insurance plan of coverage that requires patients, physicians and hospitals to work in conjunction with the carrier to coordinate the most cost-effective healthcare options.

Medicaid - A state administered, federal and state funded insurance plan for low-income people who have limited or no insurance.

Medical Record Number - The number assigned to each patient that identifies your individual medical record.

Medicare - A health insurance program for people age 65 and older. Medicare covers some people under age 65 who have disabilities or end-stage renal disease (ESRD).

Medicare + Choice - A Medicare HMO insurance plan.

Medicare Approved - Medical services for which Medicare normally pays.

Medicare Number - Every person covered under Medicare is assigned a number and issued a card for identification to providers.

Medicare Paid - The amount of your bill that Medicare paid.

Medicare Part A - Helps pay for inpatient care in hospitals and hospices, as well as some skilled nursing costs.

Medicare Part B - Helps pay for physician services and outpatient care.

Medicare Summary Notice (MSN) - The notice you receive from Medicare after getting services from your physician or hospital. It tells you what was billed to Medicare, Medicare's approved payment, the amount Medicare paid, and what you have to pay. Also called an Explanation of Medicare Benefits (EOMB).

Medigap - Medicare Supplement Insurance that pays for some services not covered by Medicare A or B, including deductible and coinsurance amounts.

MRI - A type of X-ray; magnetic resonance brain or body images, usually done in a hospital's radiology department.

N

Network - A group of physicians, hospitals, pharmacies, and other healthcare experts voluntarily enrolled in a health plan to take care of its members.*

Non-Covered Charges - Charges for medical services denied or excluded by your insurance. You may be billed for these charges.

Non-Participating Provider - A physician, hospital, or other healthcare provider that is not part of an insurance plan's physician or hospital network.

Nursery Room and Bed Charges - The cost of care for newborns whether provided in the mother's room or in the hospital nursery.

O

Observation - A type of in-hospital service ordered by your physician to determine if you need inpatient hospital care or whether you can recover at home or in an outpatient area. Observation room and bed charges are usually less than 24 hours.

Out-of-Network Provider - A physician or other healthcare provider who is not part of an insurance plan's physician or hospital network -- same as non-participating provider.

Out-of-Pocket Costs - Costs you are responsible for because Medicare or insurance does not cover them.

Outpatient Service - A service that can be performed in an outpatient ancillary department, therapy center, or in-hospital for less than 24 hours.

P

Paid to Provider - Amount the insurance company pays your medical provider.

Participating Provider - A physician or hospital that agrees to accept your insurance payment for covered services as payment in full, minus your deductibles, co-pays and coinsurance amounts as outlined in their contract

Patient Amount Due - The amount charged by your physician or hospital that you are responsible for paying.

Patient Type - A way to classify patients -- outpatient, inpatient, etc.

Pay This Amount - How much of your bill you are responsible for paying.

Per Diem - Charged or paid by the day.

Pharmacy Charges - Cost of drugs given under a pharmacist's direction.

Physical Therapy - Treatment of diseases or injuries by exercise, heat, light, and/or massage.

Physician - Person licensed to practice medicine.

Physician Extenders - Also called mid-level service providers. Physician extenders include licensed nurse practitioners and/or licensed physician assistants. They coordinate patient care under a physician's supervision.

Physician Practice - A group of physicians, nurses, and physician assistants who work together.

Policy Number - A number that your insurance company gives you to identify your contract.

Pre-Admission Approval or Certification - An agreement by your insurance company to pay for your medical treatment. Physicians and hospitals ask your insurance company for this approval before providing your medical treatment.

Primary Care Network (PCN) - A group of physicians serving as primary care physicians.

Primary Care Physician (PCP) - A physician whose practice is devoted to internal medicine, family/general practice, or pediatrics. Some insurance companies consider obstetrician/gynecologists primary care physicians.

Primary Insurance Company - The insurance company responsible for paying your claim first. If you have another insurance company, it is referred to as the secondary insurance company.

Private Room - A more expensive single hospital room. You may have to pay extra for this type of room if it is not a medical necessity.

Procedure Code (CPT Code) - A national standard coding system used to describe what treatment or services were given to you by your physician or during an outpatient hospital visit. Provider **Contract Discount** - A part of your bill that your physician or hospital must not charge you because of billing agreements with your insurance company.

Provider Name, Address, and Phone # - Name and address of the physician or hospital submitting your bill.

R

Referral - Approval needed for care beyond that provided by your primary care physician or hospital. For example, managed care plans usually require referrals from your primary care physician to see specialists or for special procedures.

Release of Information - A signed statement from patients or guarantors that allows physicians and hospitals to release medical information so that insurance companies can pay claims.

Responsible Party - The person(s) responsible for paying your hospital bill -- usually referred to as the guarantor.

Revenue Code - A national standard billing code used to name a specific room, service (radiology, laboratory), or charge group.

S

Same-Day Surgery - Outpatient surgery.

Secondary Insurance - Additional insurance plan coverage that may pay some charges not paid by your primary insurance company. Whether payment is made depends on your insurance benefits, your coverage, and your benefit coordination.

Service Begin Date - The date your medical services or treatment began.

Service Code - A code describing medical services you received.

Service End Date - The date your medical services or treatment ended.

Skilled Nursing Facility - An inpatient facility in which patients that do not need acute care are given nursing care or other therapy.

Source of Admission - The source of your admission -- referral, transfer, emergency room, etc.

Statement Covers Period - The date your services or treatment begin and end.

Submitter ID - Identification number (ID) that identifies physicians and hospitals who bill by computers. Physicians and hospitals get an ID from each insurance company to whom they send claims.

Supplemental Insurance Company - An additional insurance policy that handles claims for deductible and coinsurance reimbursement.

Swing Bed - Bed for a patient who receives skilled nursing care in a non-skilled nursing facility.

T

Total Charges - Total cost of your medical services.

Type of Admission - The reason for your admission, such as emergency, urgent, elective, etc.

Type of Bill -- A bill that shows what type of care is being billed, such as hospital inpatient, hospital outpatient, skilled nursing care, etc.

U

UB-04 - A national standard form used by hospitals to file insurance claims for medical services.

Units of Service - Measures of medical services, such as the number of hospital days, miles, pints of blood, treatments, etc.

V

W

X

Y

Z

NOTE: An asterisk (*) after a term means that this definition, in whole or in part, is taken from the Medicare Glossary, <http://www.medicare.gov>, February 2003.