Practice Finances Terms & Acronyms

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A	
Acceptance of Assignment	A physician's agreement to accept the amount established by Medicare, Medicaid, or a private insurer as full payment for covered services. The patient **is not** billed for the difference because the agreement makes it illegal to bill the patient for the balance.
Acute Treatment	CMS considers a patient's condition acute when the patient is being treated for a new injury, identified by x-ray or physical exam. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of, the patient's condition. Locate the Medical Review Policy for each carrier to identify what qualifies as an acute condition as it varies from payer to payer.
Aging	A formal medical billing term that refers to insurance claims that haven't been paid or balances owed by patients overdue more than 30 days. Aging claims may be denied if they aren't promptly filed with a health insurance company.
Allowed Charge	The maximum charge an insurance carrier/ government program covers for specific services. Allowed charges are detailed in the carrier's explanation of benefits (EOB).
Appeal	Appeal occurs when a patient or a provider tries to convince an insurance company to pay for healthcare after it has decided not to cover costs for someone on a claim. Medical billing specialists deal with appeals after a claim is denied or rejected by an insurance company.
Applied to Deductible (ATD)	The amount of money a patient owes a provider that is applied to his/her yearly deductible. A patient's deductible is determined by his/herinsurance plan and can range in price.
Assignment of Benefits	An insurance company's authorization to make payments directly to physicians.
Authorization	When a patient's health insurance plan requires him/her to get permission from the insurance providers before receiving certain healthcare services. A patient may be denied coverage if s/he sees a provider for a service that required authorization before consulting the insurance company.
Auto Posting	eEOBs /ERAs are downloaded directly into the provider's billing software requiring little to no data entry by a staff member.
B	
Balance Billing	"Billing a patient for services **not** paid for by insurance. **Note:** Managed Care plans in which the doctor participates generally prohibit balance billing. Allowed amounts such as deductibles and co-payment are the exception."
Basic Medical	Covers some or all non-surgical services provided by a physician, whether in the office, the patient's home, or a hospital. Each time a service is rendered, there is usually a copayment or coinsurance charge **and** a deductible amount that must be paid by the patient.
Beneficiary	The person named in an insurance policy to receive the benefits.
Benefit Maximum	Policy limits. Benefit maximums are usually a set dollar amount or a set number of visits per benefit period.
Benefit Period	The patient's benefit period or benefit year is the length of time benefits are paid. Most plans run on a calendar year-January through December; however, some plans run on a plan year-any specified 12-month period.
BI Liability	**B**odily **I**njury **L**iability- when you are found legally responsible for a car accident, this is the part of your insurance policy that pays for the costs associated with the injuries to the other person or people involved. It also provides legal defense if you are sued for damages.
Birthday Rule	A common claims practice health insurance companies use when children are listed as dependents on two parents' group health plans. The rule helps determine which health plan is primary and which is secondary so that total coverage does not exceed 100% of the charges. The rule states that the primary payer is determined by the parent whose birthday falls first within the calendar year. If both parents share the same birthday, the health insurance plan that has provided coverage longest is the primary payer.
BUCA	A acronym for the big four insurance carriers, Blue Cross Blue Shield, UHC, Cigna and Aetna.

C	
CA	**C**hiropractic **A**ssistant
Calendar Year	The term used to indicate an insurance plan in effect from 01/01 - 12/31.
CHAMPVA	**C**ivilian **H**ealth **a**nd **M**edical **P**rogram of the **V**eterans **A**dministration. It covers the expenses for families of veterans with total, permanent, service-connected disabilities. It also covers surviving spouses and dependent children of veterans who died in the line of duty.
Chronic Treatment	The term used when a patient's condition is not expected to significantly improve or be resolved with further treatment (e.g., an acute condition), but continued therapy may result in some functional improvement. If the clinical status for the condition is stable, and additional improvement is not expected, further manipulative treatment becomes maintenance therapy and is not covered.
Claim Appeal	A written request asking a carrier for a review of reimbursement. It is usually filed because there was no preauthorization due to unusual circumstances; inadequate reimbursement for a complicated procedure; the physician disagrees that the patient's condition was preexisting; or there were unusual circumstances that affected medical treatment.
Clean Claim	A medical claim filed with a health insurance company that is free of errors and processed in a timely manner. Some providers may send claims to organizations that specialize in producing clean claims (e.g., clearinghouses).
Clearinghouse	Facilities that review and correct medical claims before sending them to insurance companies for final processing. This meticulous editing process for claims is known in the medical billing industry as "scrubbing."
CMS	**C**enter for **M**edicare and Medicaid **S**ervices: part of the Federal Department of **H**ealth and **H**uman **S**ervices (HHS) that administers Medicare and Medicaid.
CMS 1500	CMS-1500 is the standard paper claim form used by health care professionals and suppliers to bill insurance carriers and Medicare.
CMT	**C**hiropractic **M**anipulative **T**reatment
COB	**C**oordination **o**f **B**enefits- used to establish the order in which claims are paid (e.g., when primary and secondary carriers coordinate benefits).
COBRA	**C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct- a federal regulation that allows employees and certain dependents to continue group health insurance coverage for a set period of time when coverage is lost following a qualified event (e.g., job termination, reduced work hours, etc.).
Coding	The process of translating a physician's documentation about a patient's medical condition and health services into medical codes that are then plugged into a claim for processing with an insurance company. Medical billing specialists must be familiar with a wide variety of code sets in order to perform their job duties effectively.
Coinsurance	A percentage of total costs for which the patient is responsible. In managed care plans this is often called a copayment. The physician **can** bill for coinsurance that was not collected at the time of service.
Contractual Adjustment	A binding agreement between a provider, patient, and insurance company wherein the provider agrees to write off charges on behalf of the patient. Contractual adjustments may occur when there is a discrepancy between what a provider charges for healthcare services and what an insurance company is willing to pay for that service.
Coordination of Benefits	Prevents duplicate payment for the same service (e.g., if a child is covered by both parents' insurance, a primary carrier is designated to pay benefits according to the terms of the policy. The secondary plan covers any remaining charges.)
Co-payment (Co-Pay)	"A fixed amount paid by the patient on each visit. Insurance pays the remaining, allowable amount for services. Note: A carrier's policy may require the patient to pay one copayment for chiropractic manipulation and another for therapy. Verify and note all details in order to take them into consideration when you calculate the patient's financial responsibility. "
CPT Codes:	**C**urrent **P**rocedural **T**erminology- codes that are designated to describe services rendered in the office. When placed on a CMS-1500 form, they explain the service to the insurance company representative, so payment can be made. These codes are typically 5-digits long (see the American Medical Association's (AMA) annual coding update books for the most common codes and additional information.)
Credentialing	The application process for a provider to coordinate with an insurance company. Once providers are credentialed with an insurance company, they can work with that company to provide affordable healthcare to patients.
Credit Balance	The sum shown in the "balance" column of a billing statement that reflects the amount due for services rendered.
Crossover Claim	When claim information is sent from a primary insurance carrier to a secondary insurance carrier, or vice versa.

D	
DC	**D**octor of **C**hiropractic
Date of Service (DOS)	The date when a provider performed healthcare services and procedures.
Day Sheet	A document that summarizes the services, treatments, payments, and charges a patient received on a given day.
Deductible	A fixed amount of money that must be paid annually, by the patient, before insurance begins paying benefits.
Deemed Provider	The designation given to a physician who is out of network but bills certain Medicare Private Fee for Service (PFFS) plans on behalf of the patient. The act of billing "deems" the provider as "in-network" ***for that patient***. This forces the provider to accept the fee schedule of the plan, and s/he may not balance bill the patient beyond the stated patient responsibility.
DEERS	**D**efense **E**nrollment **E**ligibility **R**eporting **S**ystem-maintained by the Department of Defense-it is a worldwide database of people covered by TRICARE.
DME	**D**urable **M**edical **E**quipment
DMEPOS	**D**urable **M**edical **E**quipment, **p**rosthetics, **o**rthotics, and **s**upplies
DOA	**D**ate **o**f **A**ccident/Injury
DOB	**D**ate **o**f **B**irth
DOI	**D**ate **o**f **I**llness/Injury
Down Coding	Occurs when an insurance company finds there is insufficient evidence on a claim to prove the provider performed coded medical services and as a result, the codes are reduced or removed. Down coding usually reduces the cost of a claim.
Dual Coverage	When a patient's health care is covered by more than one insurance plan. "Coordination of benefits" is the process insurance companies follow to ensure the combined benefits from all insurance plans do not exceed 100% of the fee.
Duplicate Coverage Inquiry (DCI)	A formal request typically submitted by an insurance carrier to determine if a patient has other health coverage.
DX	The abbreviation for diagnosis codes, also known as ICD-10 codes.
E	
EFT	**E**lectronic **F**unds **T**ransfer
E/M	**E**valuation and **M**anagement Services
EHR	**E**lectronic **H**ealth **R**ecords- an individual's aggregate, electronic record of health-related information created and gathered cumulatively across more than one healthcare organization. It is managed and consulted by licensed clinicians and staff members involved with the individual's health and care.
Electronic Billing	Submission of charges to an insurance company via electronic means-either directly to the carrier or through a clearing house.
Electronic EOBS (eEOB) /Electronic Remittance Advice (ERA)	An electronic report in a standard, computer-readable format sent by insurance companies to providers as an explanation of payment similar to the paper EOBs mailed to providers.
EMR	**E**lectronic **M**edical **R**ecords - an individual's electronic record of health-related information. It is created, gathered, managed, and consulted by licensed clinicians and staff members, from a single organization, involved in the individual's health and care.
Enrollee	A person covered by a health insurance plan.
EOB	**E**xplanation **o**f **B**enefits. This is the portion of a payment that explains how the bill was processed and how the payments were assigned to each service. It is usually attached to the check and/or sent, as a separate document, with the check. The data contained on the EOB helps the staff apply the payment to the correct dates of service.
EOMB	**E**xplanation **o**f **M**edicare **B**enefits. This is the same as an EOB, but it comes from Medicare regarding a Medicare beneficiary.
EP	**E**stablished **P**atient- a patient that has received professional services in the last three years from the treating physician or another physician in the same group and specialty.

EPO	An **E**xclusive **P**rovider **O**rganization that provides health insurance coverage using a group of providers, hospitals, and healthcare personnel but **does not** cover out-of-network services.
ERA	**E**lectronic **R**emittance **A**dvice
ERISA	**E**mployee **R**etirement **I**ncome **S**ecurity **A**ct- laws that protect plan funds and ensure that qualified participants receive their benefits.
Exclusions	Expenses that may not be covered under the insured's contract. The insured is required to pay for services not covered by the health plan.
F	
Fee Schedule	A price list for medical practices that lists services offered and the corresponding charges for those services.
Fee for Service	A type of health insurance that pays the provider for every service s/he performs. People with fee-for-service plans choose whatever hospitals and physicians they want to use for care in exchange for higher deductibles and co-pays.
Financial Report of Findings (FROF)	Part of the New Patient Procedure that takes place after the clinical report of findings. Finances are discussed and financial agreements are made once the patient accepts care.
Fraud	Knowingly and willfully executing or attempting to execute a scheme or act to defraud any healthcare benefit program. To obtain by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.
Front Desk Collections	Total collections taken from patients at the front desk (e.g., cash, checks & credit cards).
G	
Government Insurance Policies	Government-sponsored insurance coverage for eligible individuals. Federal coverage includes Medicare, Medicaid, TRICARE, or CHAMPUS/ CHAMPVA.
Group Insurance Policy	Covers groups of people under a master contract that is generally issued to employers for the benefit of their employees. These plans usually provide greater benefits at lower premiums than individual plans. Everyone in a group contract has identical coverage. Physicals aren't required for coverage.
Group Number	A number given to a patient by their insurance carrier that identifies the group or plan under which they are covered.
Guarantor	A person (other than the patient) who is paying for an insurance plan (e.g., parents are the guarantors for their children's health insurance.)
H	
Hardship Agreement	A financial agreement established when a patient is unable to pay the actual fees charged or their percentage (if insured). The practice must establish a hardship policy and ensure, through verification, that the patient qualifies.
HCFA	**H**ealth **C**are **F**inancing **A**dministration pronounced 'HICK-fah'. HCFA establishes standards for medical providers that require compliance to meet certification requirements. The preferred term is now Centers for Medicare & Medicaid Services-CMS. As a result, the term CMS 1500 form is used rather than HCFA 1500 form.
HCPCS	The standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes (e.g., ambulance services, durable medical equipment, prosthetics, orthotics, supplies, etc.).
HDHP	A **H**igh **D**eductible **H**ealth **P**lan is a health insurance plan with lower premiums and higher deductibles than a traditional health plan.
HIPAA	**H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct- this Act is the most comprehensive protection for patient's privacy rights in history. HIPAA controls how health care professionals use a patient's PHI. HIPAA includes Coding and Transactions Rules, Privacy Rules, and Security Rules.
HIPAA Eligibility Transaction System (HETS)	The HIPAA (Health Insurance Portability and Accountability Act) Eligibility Transaction System (HETS) allows you to check Medicare beneficiary eligibility data in real-time. Use HETS to prepare accurate Medicare claims, determine beneficiary liability, or check eligibility for specific services.
HITECH	**H**ealth **I**nformation and **T**echnology for **E**conomic and **C**linical **H**ealth. HITECH legislation was created to stimulate the adoption of electronic health records.
HMO	A **H**ealth **M**aintenance **O**rganization that provides health insurance coverage to its members through a network of participating providers, hospitals, and other healthcare providers.

HRA	The **H**ealth **R**eimbursement **A**ccount is an employer-funded plan that reimburses employees for health care expenses not covered by the employer's health insurance plan.
HSA	**H**ealth **S**avings **A**ccount - an account into which yearly limited maximum contributions are made by the member or his/her employer. The HSA offers tax savings implications and is used for medical expenses not covered by the member's health plan or for which the member has a high deductible
I - J - K	
ICD Codes	**I**nternational **C**lassification of **D**iseases- Codes that describe a patient's diagnosis. These codes are based on the diagnosis and are typically three digits and may have additional digits after the decimal. These codes are used to describe the condition being treated, and since insurance companies determine coverage based on the condition being treated, it's imperative to make this diagnosis as specific as possible to justify the treatment rendered. We currently use the 10th Edition, referred to as ICD-10.
Indemnity Insurance	The insurer pays the subscriber a set amount for each service or procedure performed due to illness or injury. These fees are usually paid directly to the insured unless previous arrangements were made for them to go to the provider. A fee schedule is provided to the purchaser at the start of the contract; benefits are determined on a fee-for-service basis.
Individual Insurance Policies	Individuals who do not qualify for group policies may apply for individual policies. Premiums are often higher, and the benefits aren't as good as those for group policies. Individual policies usually require applicants to pass physical examinations for coverage.
In-Network /Out-of-Network	Indicates whether a provider has contracted with a particular health care plan or not.
Insurance Benefits	The list of services and amounts paid by the insurance carrier. The schedule of benefits may indicate the carrier only pays 80% of all medical fees for Chiropractic services, leaving the subscriber responsible for the coinsurance (the remaining 20% of the medical fees). These plans are often referred to as 80:20 plans.
ITIN	**I**ndividual **T**axpayer **I**dentification **N**umber
Independent Practice Association (IPA)	The IPA is a professional organization of physicians who have a contract with an HMO.
L	
LCD	**L**ocal **C**overage **D**eterminations- a determination issued by a Medicare fiscal intermediary or a carrier under part A or part B, indicating whether or not a particular item or service is covered on an intermediary- or carrier-wide basis.
Lifetime Maximum Benefit	The total amount a health plan pays out over a patient's lifetime.
Line Item Posting	Posting a payment against the patient encounter and/or date of service for each line item, rather than posting a payment for all services across a single visit or multiple visits without itemizing
LMT	**L**icensed **M**assage **T**herapist
M	
Maintenance Treatment	According to CMS, chiropractic maintenance therapy is not considered medically reasonable or necessary under the Medicare program, and so is not payable. Maintenance therapy is defined as a treatment plan that is designed to prevent disease, promote health, and prolong and enhance the quality of life; **or** therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is considered maintenance therapy.
Major Medical	Policy to help with medical expenses resulting from catastrophic /prolonged illnesses/injuries.
Managed Care Organizations	Organizations that manage, negotiate, and contract for health care in order to keep costs down. They contract with health-care providers that agree to charge fixed fees for services. The fees are set by the managed care organization or by the government agency responsible for managed care.
Maximum Out of Pocket	The amount a patient is required to pay. After a patient reaches their maximum out of pocket level, healthcare costs should be covered by his/her plan.
MD	**M**edical **D**octor

Medi/Medi	Older or disabled patients with Medicare that cannot pay the difference between a bill and the Medicare payment may qualify for Medicare and Medicaid aka Medi/Medi. In such cases, Medicare is the primary payer and Medicaid is the secondary payer.
Medicaid	"A health benefit program designed for low-income people (people on welfare or other kinds of public assistance) who cannot pay medical bills. People with Medicaid coverage are medically indigent. Eligibility for coverage might vary from month-to-month based on the recipient's income. Medicaid is a health-cost assistance program, not an insurance program. Physicians may choose not to accept Medicaid patients. Within broad national guidelines established by Federal statutes, regulations, and policies, each State: • Establishes its own eligibility standards • Determines the type, amount, duration, and scope of services • Sets the rate of payment for services • Administers its own program
Medicaid Plan	A health benefit program designed for low-income people (people on welfare or other kinds of public assistance) who cannot pay medical bills. People with Medicaid coverage are medically indigent. Eligibility for coverage might vary from month-to-month based on the recipient's income. Medicaid is a health-cost assistance program, not an insurance program. Physicians may choose not to accept Medicaid patients.
Medical Coverage Guidelines	An insurance carrier's guidelines used to determine coverage decisions.
Medical Record Number	A unique number assigned to a person's medical record to differentiate it from other medical records.
Medical Review Policy (MRP)	This document is often available to clinics through a provider portal. Look for terms such as *Clinical Coverage Bulletin, Provider Tools, Reimbursement Policy, and Medical Review Policy and Treatment Guidelines.* These documents contain information about covered and non-covered services, medical necessity guidelines, visit limitations, non-covered procedure codes, documentation requirement, etc.
Medicare Advantage Plan	A Medicare health plan, also known as Medicare Part C, offered by private companies approved by Medicare. The Medicare Advantage Plan provides Part A and Part B coverage, and may offer additional coverage such as vision, hearing, dental, and prescription drug coverage. Also known as a Medicare Replacement Plan, it resembles managed care coverage in the traditional insurance world.
Medigap	Supplemental health insurance under Medicaid for eligible persons who need help covering co-pays, deductibles, and other large fees.
Med-Pay	**Med**ical **Pay**ments Benefits- an option you can add to your automobile insurance policy; it is intended to cover reasonable medical expenses for insured drivers and/or their passengers incurred because of an auto accident.
Member Services	A department designed to help patients with inquiries and/or concerns that may arise.
MMI/MCI	**M**aximum **M**edical **I**mprovement/**M**aximum **C**hiropractic **I**mprovement- a determination that a patient has reached maximum improvement for this condition or pre-injury status or has reached the end of an episode of care. Any care beyond this point is not "medically necessary." It becomes maintenance care and **is not** billable to a third-party carrier.
Modalities	Physiotherapies such as traction, ultrasound, electrical muscle stimulation, and hot or cold packs.
Modifier	A modifier is a two-digit or letter suffix added to a CPT code to "modify", clarify, and better define the procedure identified by the CPT code. Its purpose is to augment and further clarify.
MSP	**M**edicare is the **S**econdary **P**ayer when the beneficiary has coverage through a group health plan, worker's compensation, or there is some other third-party liability. Certain rules and procedures apply when Medicare is **secondary**, rather than primary
MVA	**M**otor **V**ehicle **A**ccident
N	
National Standard Format (NSF)	The most widely accepted format for electronically transmitting CMS forms.
NCD	**N**ational **C**overage **D**eterminations- Medicare releases NCDs when changes are made to medical services/ treatments evaluated by the Centers for Medicare and Medicaid Services (CMS) that are now covered or not covered by Medicare. Determination of coverage is often related to specific Medicare criteria and guidelines.

NMR	**N**euro**m**uscular **R**e-education- a therapeutic activity service provided to patients as part of an active care treatment protocol where improved proprioception is the primary desired outcome.
No-Fault System	A type of insurance contract under which insureds are covered for losses by their own insurance companies, regardless of fault in the incident generating losses. In this sense, it is no different from first-party coverage. Typically, in the no-fault system, the patient's own car insurance pays his/her medical expenses after an accident.
Non-Covered Charge (N/C)	Procedures and services not covered by a person's health insurance plan.
Not Elsewhere Classifiable (NEC)	A procedure or service that can't be described within the available code set.
Notice of Doctor's Lien	Doctors ask their patients and their attorneys to sign this document wherein the doctor agrees to treat a patient immediately and wait to be paid until the case is settled or won. The attorney agrees to pay the doctor's bill at settlement.
NP	**N**ew **P**atient- a qualified NP is someone who has never been to the practice before, or who has not been treated there in the last three years.
NPIN	**N**ational **P**rovider **I**dentification **N**umber.
O	
OIG	**O**ffice of the **I**nspector **G**eneral from the Department of Health and Human Services. This department is assigned to ensure that rules are followed with regard to compliance and relative to fraud and abuse in Federal health care programs (e.g., Medicare, Medicaid, Tri-Care, (formerly Champus), and sometimes the Federal Employee Health Benefits Program (FEHBP).)
OON	**O**ut **o**f **N**etwork
Ordering Provider	The individual who requested services or items. This is reported as a specific line item on a 1500 Claim form (e.g., provider ordering diagnostic tests, medical equipment, or supplies).
Out of Pocket Max	Also known as stop loss. Out of pocket maximum refers to a set dollar amount that the patient will pay out of pocket. Once satisfied, the insurance company pays 100% of **eligible** expenses for the rest of the benefit period.
Overpayment	Payment by the insurer or the patient that was more than the amount due.
P	
Pain and Suffering	A legal term for the physical and emotional stress caused from an injury. It is also the monetary amount designated for the physical pain and emotional distress the patient endures as a result of a personal injury accident.
Paper Claim	Aka: the universal claim or the CMS-1500 claim form (or the CMS-1500). Practices that use paper claims must have two versions of their medical billing software: one to capture the necessary data for HIPAA-compliant electronic Medicare claims and an older version to generate CMS-1500 claims.
PAPI	An acronym for **P**ayer **A**ssigned **P**rovider **I**D utilized by Availity and some payer portals.
Payment	Cash, check, credit card payment, insurance payment, or money order received for professional services rendered.
Payer ID	Insurance carrier reference number for electronic billing.
PCP	**P**rimary **C**are **P**hysician.
Peer Review Organizations	Groups of practicing physicians paid by insurance companies to review medical records for effectiveness and efficiency. The reviews are to monitor the validity of diagnoses, the quality of care, and to evaluate the appropriateness of hospital admissions and discharges.
Personal Injury Protection (PIP)	An extension of car insurance that covers medical expenses and, in many cases, lost wages. Often called "no-fault" coverage because claims are paid regardless of who was at fault.
PFFS	A **P**rivate **F**ee-**F**or-**S**ervice plan is a Medicare Advantage (MA) health plan that provides beneficiaries with Medicare benefits plus any additional benefits the company decides to provide. Beneficiaries can see any provider eligible to receive payment from Medicare and agrees to accept payment from the PFFS MA. (See Deemed Provider)
PIP	**P**ersonal **I**njury **P**rotection-if you live in certain states, you may be required to carry PIP insurance. It pays for covered medical expenses for any injuries you suffer in an automobile accident. This coverage pays the injured party's medical expenses up to the stated limit.

Plan Year	The 12-month period in which an insurance plan is effective. A policy with a plan year (instead of a *calendar year*) does not start January 1 and end December 31. Instead, effective dates are verified during the benefit verification process.
Portal	A website that requires a user name and password in order to access confidential provider and/or patient information.
POS	A **P**oint **o**f **S**ervice carrier that provides health insurance coverage and allows members to go outside of provider and hospital networks, but results in higher out-of-pocket costs.
PPACA	**P**atient **P**rotection and **A**ffordable **C**are **A**ct- a health care reform bill, signed into law in March 2010, to give citizens easier access to healthcare. Changes are ongoing and are being implemented over time. (AKA: Obamacare or ACA).
PPI (Michigan)	**P**roperty **P**rotection **I**nsurance- provides protection if you cause damage to properly parked vehicles or fixed properties such as buildings or lampposts in the state of Michigan. Outside Michigan, your Property Damage Liability Insurance covers your legal liability for property damage.
PPO	A **P**referred **P**rovider **O**rganization provides health insurance coverage using a group of providers, hospitals, and other healthcare providers that contract with the carrier to provide services at a discounted/contracted rate. The PPO also provides health insurance coverage for services rendered by out-of-network providers, but at a higher out-of-pocket cost to the member.
Practice Management Software	Office software used for scheduling, billing, and recordkeeping.
Preauthorization	Permissions granted by the insurance carrier that must be obtained before starting certain treatments for patients.
Precertification	A call to the patient's insurance carrier to find out whether the treatment, surgery, tests, or hospitalization is covered under the patient's health insurance policy.
Pre-Existing	A condition the patient had prior to enrolling for insurance, which may or may not preclude coverage.
Premium	The amount charged for a medical insurance policy. The insurer agrees to provide certain benefits in return for the premium - aka coverage cost.
Primary Carrier	When there's more than one insurance carrier, *coordination of benefits* rules decide which one pays first. The **primary payer** pays first and the **secondary payer** covers the balance.
Proactive Calls	Calls made to insurance companies when an aging report indicates that a bill or date-of-service is at least 30 days old. The call is proactive because the staff member used an aging report to determine the bill was overdue and called to find out the current status of the payment.
Protected Health Information (PHI)	A subset of health information (including demographic information) that: 1. Is created or received by a health-care provider, health plan, employer, or health-care clearinghouse 2. Relates to the past, present, or future physical or mental health or condition; or to the provision of health care for an individual 3. Identifies the individual 4. Leaves reason to believe the information can be used to identify an individual
Provider Nonparticipating (Non-PAR)	A physician or other health-care provider that has not joined a particular insurance plan. Patients obtaining services from nonPAR providers often pay more of the costs than those receiving services from PAR Providers (aka In-Network).
Provider Participating (Par)	A physician or other health-care provider that participates in an insurance carrier's plan. Participating providers must write off (not charge a patient for) disallowed and/or ineligible charges (aka In-Network).
Provider Relations	Department designed to help physician's office personnel with inquiries about capitation, contracts, credentialing, physician appeals, formularies, etc.
PT	**P**hysical **T**herapist
PTA	**P**hysical **T**herapy **A**ssistant
PTAN	**P**rovider **T**ransaction **A**ccess **N**umber- a number assigned to a Medicare provider required for ID when billing inquiries are made to the carrier.

Q - R	
Reactivation	When a previous patient returns for an active episode of care.
Reactive Calls	A holding place for items that are a "reaction" to something else and that require discussion before they can be resolved. These are generated by a variety of scenarios (e.g., denial for payment, payments with incorrect information, claims that need to be reprocessed).
Referrals	In managed care, the primary care physician must refer a patient to a specialist before the patient can make an appointment with the specialist. A referral form must be completed listing the following: • Referring physician • Specialist to whom the patient is being referred • Diagnosis • Treatment (past and present, including medications) • Chart notes • Minor surgical procedures
Referring Provider	The individual who directed the patient to the provider rendering the reported services (e.g., primary care provider refers patient to a specialist; orthodontist refers to an oral surgeon; physician refers to a physical therapist; provider refers to a home health agency).
Remittance Advice	The information a payer sends along with payments and/or claim denials. It is an accounting of the amount billed, the amount disallowed (if any), any copayments, coinsurance or deductible amounts, as well as the amount reimbursed.
Remark Codes	Codes on an explanation of benefits (EOB) or remittance advice explaining claim processing.
Rendering Provider	The person or company (laboratory or other facility) that rendered care (e.g., a substitute provider [locum tenens]). Individuals performing services in support roles, such as lab technicians or radiology technicians are not considered Rendering Providers.
Report of Findings (ROF)	A process the doctor uses to explain clinical findings and his/her recommendations for care. Typically performed on the patient's second visit. If the patient is accepted for care and agrees to treatment, it is usually followed by the Financial Report of Findings. (See FROF)
Revalidation	Provisions in the Affordable Care Act (ACA) require all providers to revalidate or renew Medicaid and/or Medicare provider agreements **every five years**. Most state Medicaid carriers terminate provider agreements for failure to revalidate on time or if the revalidation application is not completed.
RVU	**R**elative **V**alue **U**nit- one component used to calculate the dollar value of a particular CPT code. When calculated against geographic indices, this unit value helps determine the appropriate fee for a code.
S	
SBC (Summary of Benefits & Coverage)	Companies must provide patients with a short, plain-language summary and a Uniform Glossary of terms. The SBC includes details (aka coverage examples) that often address coverage for diabetes care and childbirth.
Scrubbing	A process by which insurance claims are checked for errors before being sent to an insurance company for final processing. Providers scrub claims to reduce denied or rejected claims.
Self-Pay	Payment the patient makes to a provider for healthcare at the time the care is rendered.
Self-Referral	When a patient does his/her own research to find a provider and acts outside the primary care physician's referral.
Signature on File (SOF)	A patient's official signature kept on file for the purpose of billing and claims processing.
Slip and Fall	A term used for a personal injury case in which a person slips/trips and is injured on someone else's property (AKA: "premises liability" claims).
Stark Laws	Federal laws governing how referrals can be made, remuneration for referrals, and referrals to entities in which the referring physician (or his/her relatives) has a financial interest.
Subrogation	A clause that gives the insurance company the right to recover the amount paid on behalf of the insured from the adverse party that caused the loss.
Subscriber	The principal in an insurance contract.
Summary Plan Documents (SPD)	A detailed guide (can be more than 150 pages) to benefits the plan provides and explanations of how the plan works. It is the main vehicle used to communicate plan rights and obligations to participants and beneficiaries.

Supervising Provider	The individual who oversees the Rendering Provider and the care being reported (e.g., supervisor watching a resident).
Supplemental Health Plan	Policies that pay in addition to a patient's comprehensive major medical coverage.
T	
Third-Party Payer	A health plan or other entity that agrees to carry the risk of paying for a patient's medical services.
Tax Identification Number (TIN)	A unique number for billing purposes that a patient or company may have to produce in order to receive healthcare from a provider. The TIN is also known as the employment identification number (EIN).
Taxonomy Code	Medical billing specialists use this unique code set to identify a healthcare provider's specialty field.
Term Date	The insurance policy contract end date, or the date after which a person no longer receives or is eligible for coverage from the company. Term dates are set on a case-by-case basis.
Tertiary Insurance Claim	A claim filed by a provider after filing claims for primary and secondary health insurance **coverage** on behalf of a patient. Tertiary insurance claims often cover the remaining healthcare costs such as deductibles and co-pays remaining after the primary and secondary claims are processed.
Tickler System	A file or electronic system that provides reminders daily/monthly about previously scheduled activities and tasks.
Time-of-Service Discount (TOS)	Also known as a prompt payment discount, this is a set discount allowed when the patient pays at the time of service. The OIG determined that 5-15% is an appropriate Time-of-Service discount for federally insured patients. Some states have specific laws that may allow larger time-of-service discounts for non-federally insured patients.
TPA	**T**hird **P**arty **A**dministrator- agencies that process claims and perform administrative services as part of a service contract with an insurance carrier.
Treatment Authorization Request (TAR)	A unique number the insurance company gives the provider for billing purposes. A provider must have the insurance company's TAR number before administering healthcare to a patient covered by the company.
TRICARE Insurance	TRICARE (aka CHAMPUS/ CHAMPVA) are the most common health-care policies for military personnel and their families. These agencies are run by the Defense Department. TRICARE is a Health care benefit specifically for families of uniformed personnel and retirees from the uniformed services (e.g., Army, Navy, Marines, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration).
TX	**T**reatment
U	
UCC Lien	(**U**niform **C**ommercial **C**ode Lien) A legal form that creditors file to give notice that they have or may have an interest in the settlement of a personal injury claim. This lien differs from a Notice of Doctor's Lien in that providers file the lien directly depending on their state and county requirements. The lien provides the doctor an assignment of benefits in a 3rd party claim.
UCR	**U**sual, **C**ustomary, and **R**easonable (aka - R&C for reasonable and customary). This is verbiage used by an insurance company to define the "standard" number of visits required for a patient's condition. UCR or R&C can also be used to determine fees for certain codes. Insurance companies use geographic averages or other published data to determine appropriate fees.
UIM	**U**nder **I**nsured **M**otorist coverage- Uses a patient's own auto insurance policy when an accident occurs with an at-fault driver whose liability limits are too low to cover the damages or medical expenses.
UM	**U**ninsured **M**otorist Coverage- Part of a policy that activates when the insured is involved in an accident with an at-fault driver with no liability insurance- technically, it becomes the third-party coverage. When patients file claims against their own UM coverage, they are "suing" their own insurance for damages, pain and suffering, and medical expenses.
UM BI	**U**ninsured **M**otorist **B**odily **I**njury coverage pays bodily injury or death expenses for you and/or any passengers in your vehicle up to the policy limit if struck by an uninsured driver or if you're struck by a "hit-and-run" driver that cannot be identified.
Unbundling	The fraudulent practice of ascribing more than one code to a service or procedure on a superbill or claim form when only one is necessary.
Untimely Submission	There is a specific timeframe in which claims can be submitted to an insurance company for processing. If a provider fails to file a claim in that timeframe, it is marked for untimely submission and will be denied by the company.

Upcoding	The fraudulent practice of ascribing a higher ICD-9 code to a healthcare procedure in an attempt to get more money than necessary from the insurance company or patient.
Utilization Review	Examination of services by an outside group. A utilization review committee looks at individual cases to make sure that services were medically necessary.
V - W - X - Y - Z	
Virtual Credit Cards	A 16-digit credit card number generated for a single payment and for a predetermined amount-there is no physical card. These may appear on EOBs as payments instead of EFTs or paper checks.
WC	**W**orker's **C**ompensation- Insurance covering employees' injuries or illnesses arising from the course of their employment.
Workers' Compensation Claims Processing	Follow these guidelines: Records of the workers' compensation case should be kept separate from the patient's regular history. The insurance carrier is entitled to receive copies of all records pertaining to the industrial injury. The injured person's records must be personally signed by the physician. The insurance carrier may supply its own billing forms. Payment is usually made on the basis of a fee schedule. At the termination of the treatment, a final report and bill are sent to the insurance carrier.
Write Off	Total dollar amount written off due to contractual obligations, non-covered services, bad debts, or financial agreements.