US HEALTH INSURANCE TERMS

A

Accumulation Period: The period of time during which an insured person incurs eligible medical expenses toward the satisfaction of a deductible.

Actual Charge: The actual dollar amount charged by a physician or other provider for medical services rendered, as distinguished from the allowable charge.

Adjudication: Adjudication refers to the legal process of resolving a dispute or deciding a case. Adjudication is the process of reviewing and paying, or denying, claims that have been submitted by a healthcare provider. After receiving the claims from the health care provider, the insurance company spends some time adjudicating the claims.

Adjudication code: Adjudication code refers to the outcome of a claim or reimbursement request submitted to an insurance company or payer by healthcare providers. During the processing of a healthcare claim, it undergoes a process called adjudication, wherein the insurance company or payer carefully examines the claim to ensure its accuracy, assesses the coverage and benefits applicable, and calculates the reimbursement amount to be provided.

Adjunction date: Adjudication date refers to the specific date on which a claim or reimbursement request is reviewed and processed by the insurance company or payer during the adjudication process.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Arbitration: Arbitration is a method of resolving the dispute between two parties outside the court with the help third neutral party called an arbitrator. In an arbitration agreement, patients and providers agree to submit their dispute to one or more neutral third parties(arbitrators), who hear evidence and arguments from both sides and render a binding decision.

Attending Physician Statement (APS): A physician's assessment of a patient's state of health as outlined in office notes and test results compiled by the physician. An APS may be requested by an insurance company in lieu of a medical examination in order to determine the state of a health insurance applicant's health for underwriting purposes.

Authorization: Authorization refers to the process where the providers(Hospitals) determine the coverage of the plan, and the payer(Insurance) authorizes to pay for the rendered service or treatment.

Authorization number/Approval code: It is a unique identifier assigned by an insurance company or payer to indicate approval for a specific healthcare service. It serves as confirmation that the insurance company has authorized coverage for the claimed healthcare service.

B

Benefit: A general term referring to any service (such as an office visit, laboratory test, surgical procedure, etc.) or supply (such as prescription drugs, durable medical equipment, etc.) covered by a health insurance plan in the normal course of a patient's healthcare.

Benefit Level: The maximum amount a health insurance company agrees to pay for a specific covered benefit.

Benefit Code: Benefit codes are alphanumeric codes that are used to determine the coverage and payment for specific healthcare services under a health insurance plan. They help communicate the type of service rendered or benefit provided to the insurance company or payer. By using the appropriate benefit codes, healthcare providers can ensure accurate claims and reimbursement for the services they provide during the medical billing and coding process.

Benefit Package: A description of the healthcare services and supplies that a health insurance company covers for members of a specific health insurance plan.

Billing Provider: In the US healthcare system, billing providers are entities that submit claims for healthcare services provided(by hospitals)to patients and insurance companies in order to receive payment from insurance companies, government programs, or patients directly.

Billed amount vs Allowed amount: Billed amount represent the total amount that the healthcare provider invoices or bills for the services rendered. It is the initial amount that the provider claim to the insurance company or payer for reimbursement. But, the allowed amount refers to the reimbursable amount or approved amount. It is the maximum amount that the insurance company or payer agrees to pay for the particular healthcare service.

C

Capitation: Capitation is a payment model where healthcare providers are paid a fixed amount of money per patient for a specific period of time, typically a year, regardless of the number of services that the patient receives during that time. Health maintenance organizations (HMOs) and independent practice associations (IPAs) often use capitation programs.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copay/Co-Payment: It is a fixed amount that needs to be paid by a subscriber(patient) to the service provider before receiving the service on each visit. Usually, it is defined in the policy and is probably mentioned in the insurance card. For example: If the copay is $20 for a subscriber policy, then on each visit to the hospital he/she needs to pay $20 before medical service begins.

Carrier: Any insurer, managed care organization, or group hospital plan, as defined by applicable state law.

Carry-over Provision: A provision of some health insurance plans allowing medical expenses paid for by the member in the last three months of the year to be carried over and applied toward the next year's deductible.

Catastrophic Plan: Catastrophic health insurance plans have low monthly premiums and very high deductibles. They may be an affordable way for patients to protect themselves from worst-case scenarios, like getting seriously sick or injured, however, patients pay most routine medical expenses themselves.

Co-Insurance: It is a risk-sharing agreement between the insured and insurer under a particular insurance policy where the subscriber/insured agrees to cover the percentage of the losses(medical bill)after the deductible is paid by the insured. It is the percentage of covered service cost that the subscriber should pay after the subscriber has paid his/her deductible.

COBRA(Consolidated Omnibus Budget Reconciliation Act): According to Investopedia, COBRA is a health insurance program that allows eligible employees and their dependents the continued benefits of health insurance coverage when an employee loses their job or experiences a reduction of work hours.

COBRA Code: COBRA code refers to whether the employee is working or not. For example: 00 code refers to not Specified 01 refers to working and 02 refers to terminated.

Coordination of benefits paid amount: The coordination of benefits paid amount refers to the portion of a healthcare claim that is paid by the secondary insurance company in a situation where an individual has multiple insurance policies.

CPT(Current Procedural Terminology): According to AMA(American Medical Association, maintainer of CPT codes) CPT codes offer doctors and healthcare professionals a uniform language for coding medical services and procedures to streamline reporting, and increase accuracy and efficiency. CPT codes are five-digit codes and can be either numeric or alphanumeric depending on the category with descriptive terms for reporting.

Crossover claim: crossover claim refers to a medical insurance claim that involves multiple insurance plans. This commonly happens when a patient has coverage under both Medicare and Medicaid or when they have primary insurance with an additional secondary plan. In such cases, the primary insurance is responsible for paying the majority of the claim, while the secondary insurance covers the remaining claim amount.

D

DAW(Dispensed as Written): Dispensed as Written" (DAW) is an instruction that can be included on a prescription by a prescriber (or healthcare provider) and indicates that the prescriber wants the pharmacist to dispense the exact brand-name medication prescribed, rather than substituting it with a generic equivalent or another brand.

DEA number: A DEA Registration Number is a unique identifier provided by the Drug Enforcement Agency to medical practitioners like pharmacists, nurse practitioners, doctors, dentists, etc… allowing them to prescribe, dispense and administer drugs defined to be Controlled Dangerous Substances (CDS).

Deductibles: The fixed amounts that the insured/subscriber needs to pay to the provider for covered health care services before the insurance benefit plan starts to pay. It is the amount you pay before your insurance kicks in. For example: If you need to pay $1000 for a CT scan and $2000 for MRI, and you have a $500 deductible in your policy, then you will need to pay $500 deductible for a CT scan, and then the rest($2500) will be paid by the insurance company.

Dependent: Dependent is a person who is eligible for coverage under a policyholder's health insurance coverage. Example: Insurance coverage for the family of the policyholder, such as spouses, children, partners etc.

Demographic Information: Demographic Information refers to socioeconomic information that describes the features or characteristics of the individual or population such as name, sex, race, address, employment, income, education etc.

Denial of claim: Denial of claim is the refusal of an insurance company to a request by a healthcare provider to pay for healthcare services obtained by patients from the healthcare professional.

dispensing fee: A dispensing fee is a charge that pharmacies add to the cost of prescription medication to cover the cost associated with dispensing the medication. In easy words, It is a service fee that compensates the pharmacy for activities such as receiving, verifying, and filling prescriptions, providing patient counselling, maintaining records, and managing inventory.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics. Emergency Medical Condition.

E

EIN(Employer Identification Number): An Employer Identification Number (EIN) also known as a Federal Tax Identification Number is a unique nine-digit number assigned by the Internal Revenue Service to each business entity and is used to identify a business entity.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

EPO(Exclusive Provider Organization): A small network of providers like HMO but not compulsory to select a primary care provider(PCP) always before getting service with a Specialist.

F

Fee Schedule: Fee schedule refers to a complete list of fees used by insurance to pay doctors/providers on the basis of the medical services they provided. Here is an example of a fee schedule for a primary care physician in the US: Office visit (new patient):$150, Office visit (established patient): $100, Blood Test: $50, ECG: $75, X-ray: $150 etc.

Formulary: Formulary is a list of medications/drugs covered by a health insurance plan.

Formulary plan code: The formulary plan code is a unique identifier assigned to a particular health insurance plan's formulary. It helps distinguish the formulary of one plan from another, particularly in systems or databases that handle multiple plans.

Formulary flag: Formulary flag is a symbol/indicator, used to identify whether a specific medication is included in the formulary and the associated coverage details.

G

Grievance: A complaint that you communicate to your health insurer or plan.

Global period: Global period is a specified period before and after a surgical procedure where all related medical services are combined and charged as a single payment. This payment encompasses all services related to the surgery, including preoperative visits, the surgical procedure itself, and postoperative visits. The duration of the global period is set by the Medicare Physician Fee Schedule, usually 10 days for minor surgeries and 90 days for major surgeries. Within this time frame, any related services given to the patient are considered to be included in the bundled payment and cannot be billed separately.

Guarantor: Guarantor refers to the person who is ultimately responsible for the patient's bill. This person is not necessarily the same as the subscriber. If the patient is a child, then the guarantor might be the child's parent or legal guardian.

H

Healthcare Common Procedure Coding System(HCPCS) Code: HCPCS is a collection of standardized codes that represent medical procedures, supplies, products and services. The codes are used to facilitate the processing of health insurance claims by Medicare and other insurers.

HICN(Health insurance claim number): A health insurance claim number is a unique identifier assigned to each health insurance claim. It is provided by the health insurance company or the administrator(medical biller) handling the claims process.

HMO(Health Maintenance Organization): A small network of providers having the requirement to select a primary care provider(PCP) before getting service with a Specialist.

HMO Plan: HMO Plan is a health insurance plan that provides health services through a network of doctors for a monthly or annual fee. In HMO, patients need to choose their PCP, and PCP refers to specialists if needed. HMO only covers In-network services and has lower premiums in comparison to the PPO plan.

Home Health Care: Health care services a person receives at home.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

I

ICD(International Classification of Diseases): It is a system of codes used to classify and identify diseases, injuries, and other health conditions. The ICD is maintained by the World Health Organization (WHO) and is used by healthcare providers and researchers around the world to record and track patient diagnoses and treatments, which can be used for billing purposes, research, and public health surveillance. ICD codes consist of 3–7 digits alphanumeric codes that represent different diagnoses and procedures. The eleventh revision of the ICD code is ICD-11.

Insurance Company: Insurance company refers to the companies that cover expenses the policyholder incurs from damages to health or property and financial losses like a loss of income.

Insurance check number: An insurance check number is a unique identifier assigned to a payment check issued by an insurance company to a healthcare provider for a claim. It helps providers track and reconcile their payments, ensuring accurate financial records.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network providers: A provider network is a list of doctors, other health care providers, and hospitals that contract with a health insurance carrier(insurance company) to provide medical care to its members.

M

Medicare: Medicare is a government national health insurance program in the United States. It is the U.S. federal health insurance program for people aged 65 years or older and people with certain disabilities. Medicare pays for hospital stays, medical services, and some prescription drugs but people who receive Medicare must pay part of their healthcare costs.

Medicaid: Medicaid is a joint federal and state program that provides coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities.

Medical Billing: In the medical billing process, the healthcare provider obtains insurance information from a patient, files it and submits claims to insurance companies and billing patients(subscribers) in order to receive payment for services rendered, such as testing, treatments, and procedures.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

MRN(Medical Record Number): The unique identifier the provider assigns to reference a single patient.

Modifiers: Modifiers are used when the doctor decides to perform a procedure in a slightly different manner without changing its definition. Depending on the code for the medical procedure, the doctor is required to record the need for the alternation of the procedure to get compensation for services. CPT Modifiers are two digits numeric codes and are used to give additional information on medical procedures describing the need to use medical procedures, the site of the procedure, change in procedure, and the total number of surgeons performing the procedures. All of this information is represented in the 'CPT code — modifier' format and forwarded to the insurance payer. For example, 24115–52 is used to represent reduced services by the physician for "excision or curettage of a bone cyst or benign tumor, humerus; with autograft (includes obtaining the graft)" due to minor complications.

N

NABP(National Association of Boards of Pharmacy): NABP is an organization in the United States that works to support the state boards of pharmacy in protecting public health by ensuring the safe and effective use of medications.

NDC(National Drug Code): It is a universal unique product identifier for human drugs in the united states. It is a three-segment number that identifies the labeler(4 or 5 digits, identifies manufacturer/distributor), product(3 or 4 digits, identifies the specific drug product including strength and dosage form) and package code(2 or 3 digit, identifies package size and type)

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network flag: A network flag is a code or indicator used by insurance companies to identify whether a healthcare provider(healthcare professionals) or facility(location of health service) is in-network or out-of-network.

Non-Preferred Provider: A provider who doesn't have a contract with your health

insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

NPI(National Provider Identifier): According to Wikipedia, NPI is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare and Medicaid Services. Simply it is the unique identification number for covered healthcare providers (hospitals).

O

Out-of-network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out of-network co-insurance usually costs you more than in network co-insurance.

Out-of-network providers: An out-of-network provider is a doctor or health care provider that does not have a contract set up with your health insurance carrier.

Out-of-Pocket Limit: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

out-of-pocket maximum: Out-of-pocket maximum is the most an insured have to pay for covered medical expenses in a plan year. The amount includes money an insured spend on deductibles, copays, and coinsurance. Once the insured reaches his/her annual out-of-pocket maximum then, covered costs will be paid by the insurance plan for the rest of the plan year.

Overpayment, offset adjustment, reversal and refund: Overpayment occurs when an insurance company or patient pays more than the actual cost of medical service or treatment. Overpayments can occur due to billing errors, incorrect coding, or other administrative mistakes. Offset adjustment refers to the process of deducting or offsetting an overpayment from the invoice or future payment, or sometime refunding the offset amount. Reversal refers to the cancellation or reversal of a financial transaction that has already been processed. Refund is the process of returning the overpaid amount to the patient/entity who made the excess payment.

P

Patient: Patient refers to a person who goes to the doctor for treatment/service.

Patient responsibilities: Patient responsibilities refer to certain cost-sharing amounts that the insured/subscriber needs to be paid directly to the provider(Hospital). There are different types of patient responsibilities such as Deductibles, Copay, Co-Insurance etc.

PBM(Pharmacy Benefit Manager): According to NAIC(National Association of Insurance Commissioners), Pharmacy Benefit Managers (PBMs) are third-party companies that function as intermediaries between insurance providers and pharmaceutical manufacturers. BMs create formularies, negotiate rebates (discounts paid by a drug manufacturer to a PBM) with manufacturers, process claims, create pharmacy networks, review drug utilization, and occasionally manage to mail-order specialty pharmacies.

Provider: Provider refers to the organization that treats the patients such as Hospital, clinic etc.

Practice: Practice refers to a place where the services are performed. Examples: Pain management center of Georgia, Andrew Spencer Clinic etc.

PCP(Primary Care Physician/Primary Care Provider): PCP refers to the healthcare professionals(Doctors) who practice general medicine and see the patient for the first time for disease or illness and refer it to a specialist. In US Healthcare, some insurance plans must require a PCP. Examples: Family Doctors, Family Physician etc.

Physician Services: Health care services a licensed medical physician (M.D. –

Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan ID: Plan ID is a unique identifier assigned to a health insurance plan. Plan ID is used to distinguish one plan from another plan.

Plan maximum/Plan Limit/Benefit maximum: A plan maximum is a maximum amount that the insurance policy will pay for covered services or expenses.

Plan Type: Plan type refers to the specific type of healthcare coverage you have enrolled in. There are several types of health insurance plans, each with their own benefits, limitations, and costs.

Policy: A health insurance policy is a legal contract between you and the insurance company that outlines the terms and conditions of insurance coverage. The policy explains what is covered under the plan, the exclusions and limitations of coverage, the procedures for filing claims, and the rules for cancelling or renewing your coverage.

POS(place of service): A place of service is a location where medical services are performed by healthcare professionals. The place of service is mentioned in the place of service code. It is a two-digit code. For example, 01 refers to a pharmacy, 03 refers to a school, 09 refers to prison, 11 refers to an office etc.

Premium: Premium is an amount paid periodically(monthly/quarterly/annually) to the insurer(insurance company) by the insured(policy subscriber) for covering his/her risks.

PPO(Preferred Provider Organization): A large network of providers without being required to select a primary care provider (PCP).

PPO Plan: Preferred Provider Organization (PPO) is a health plan that offers a large network of participating providers and facilities so you have a range of doctors and hospitals to choose from. In PPO, patients have the freedom to choose their providers. It covers out-of-network services and has higher premiums in comparison to the HMO plan.

POS(Point of Service) Plan: A point-of-service plan (POS) is a type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services. When patients go out of the network, they'll have to pay most of the cost, unless the primary care provider has made a referral to the out-of-network provider.

Q

Qualifying Event: An event (such as termination or employment, divorce or the death of the employee) that triggers a group health insurance member's protection under COBRA.

R

Referral: You may know that referral refers to directing a patient to a medical specialist. In some insurance plans, a patient must be referred by PCP before being seen by a Specialist

Repricers (Brokers): "Repricers" are those acting as "brokers" - whose sole purpose is finding and applying the lowest discounted rate for its clients, often without authorization from the physician. This is also called a Silent PPO.

Relative Value Unit (RVU): Relative value units (RVUs) are a measure of value used in the United States Medicare reimbursement formula for physician services.[1] RVUs are a part of the resource-based relative value scale (RBRVS).

rev/ Revenue code: Revenue codes are standardized codes used in healthcare billing to identify specific categories or types of services or supplies provided to patients. For example, a revenue code might indicate services provided in the emergency department, laboratory tests, or pharmacy supplies. These codes help in tracking and reporting financial information within healthcare organizations and facilitate proper reimbursement processes.

Rx Drug Plan: Prescription insurance, often referred to as a prescription drug plan, is an insurance policy that covers all or part of the cost of prescription medications. Prescription drug plans can be purchased on an individual basis or can be offered as part of a group-sponsored health benefit package. Most health insurance plans have provisions for prescription drugs.

S

SBC(Summary of Benefits and Coverage) Documents: SBC documents are standardized summaries that provide clear and concise information about health insurance plans to help individuals compare and understand their coverage options. It includes coverage overview, cost sharing, examples of coverage, limitations and exceptions, coverage period, contact information etc.

Silent PPO (aka "Rental Network"): A silent PPO can be defined as an undisclosed network in which payers or managed care companies assume a preferential rate but do not disclose that rate. It is a complicated repricing scheme that was not intended by the creators of managed care products. It is also known as hijacking discounted rate through a deceptive market practice. The insurance company sees they don't have a contract with your provider for this patient, so they "borrow" a contract rate when adjudicating the claim.

SSN(Social Security Number): According to Wikipedia, a Social Security number is a nine-digit number issued to U.S. citizens, permanent residents, and temporary residents under section 205 of the Social Security Act. The number is used to track the earnings history of U.S. citizens, permanent residents, and certain non-immigrant workers.

Subrogation: The process by which a health insurance company determines whether medical bills should be paid for by the health insurance company itself or by another insurer or third party. For example, claims are frequently subject to subrogation when medical care is rendered as the result of an automobile accident. In most cases the automobile insurer is considered the primary payer. When a health insurance company has determined through the subrogation process that the automobile insurer will no longer pay on medical claims, then the health insurance company will typically become the primary payer.

Subscriber/Policyholder: Subscriber refers to the person who subscribes Policy from the insurance company by paying a regular premium to minimize probable future risks.

Specialist: A specialist is a person who has a specialty in a particular field. In Healthcare, Specialist refers to Doctors who specialize to treat a particular type of disease or organ. Example: Cardiologist, Gynecologist, Neurologist etc.

T

Third Party Administrator (TPA): A third-party administrator, otherwise known as a TPA, is a business organization that performs administrative services for a health plan such as billing, plan design, claims processing, record keeping, and regulatory compliance activities. TPAs are sometimes referred to as Administrative Services Only (ASO) entity.

Third-Party Payer: Any payer for health care services other than the patient. This can be an insurance company, an HMO, a PPO, or the federal government.

TIN(Taxpayer Identification Number): TIN is a unique identifying number used for tax purposes that identify individuals, corporations, and other entities such as nonprofit organizations (NPOs).

TOS(type of service): TOS refers to the medical code used to refer to the type of healthcare service provided to the patient. TOS codes are used by healthcare providers, facilities, and insurance companies to bill and reimburse for healthcare services accurately. For example, TOS 1 refers to medical care, TOS 2 refers to surgical services etc.

U

usual, customary and reasonable (UCR)fee: The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. In other words, It refers to the allowed amount or reimbursement rates that insurance companies consider to be reasonable charges for medical services or procedures in a specific geographic area.

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