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HOSPITAL TERMS

Critical Access Hospital (CAH)	A designation given to eligible rural hospitals by CMS and was put in place to reduce the financial vulnerability of rural hospitals. The criteria to be a CAH: • 25 or fewer acute care inpatient beds • Located more than 35 miles from another hospital
Long Term Acute Care (LTAC)	A hospital specializing in treating patients that require extended hospitalization.
Prospective Payment System (PPS)	The prices that hospitals get paid from Medicare for certain services. CAHs receive different reimbursement given their designation otherwise.
Rural	Rural hospitals make up more than half of all hospitals in the United States, they provide essential access to inpatient, outpatient and emergency services in rural communities.
Rural Health Clinic (RHC)	The RHC program is intended to increase access to primary care in rural communities, to receive certification, they must be located in rural, underserved areas.
Skilled Nursing Facility (SNF)	Special facility or part of a hospital that provides medically necessary professional services from nurses, physical and occupational therapists, speech pathologists and audiologists.
Short Term Acute Care (STAC)	A hospital that treats patients for brief but severe episodes of illness.

TECHNOLOGY COMPONENTS OF HEALTHCARE

Claim scrubber	Software that aims to rid medical claims of errors and omissions
Clearinghouse	Prior to submitting claims, the clearinghouse scrubs a claim and checks for errors. Clearinghouses

	electronically transmit claim information that is compliant with HIPAA standards.
Community Connect	A shared instance of larger EMRs (Epic, Cerner, etc.) that certain hospital systems can provide to smaller regional facilities. Often available at a lower cost but limited in customization options.
Electronic Health (Medical) Record	A digital version of a patient's paper chart.
(EHR/EMR)	Examples of EHR Systems: Meditech, Epic, Cerner, CPSI, etc.
Patient Accounting System	A subsystem of a hospital information system used for storing financial data, calculation healthcare costs, and providing billing information.
Telehealth	The use of electronic information and telecommunications technologies to support long distance clinical health care

COMMON INSURANCE TERMS

Payers and Payer Related Terms

ADR (Additional Development Request)	Request for additional documentation on the claim.
ASB (Accelerated Secondary Billing)	Automates the processing of Medicare Part A secondary claims.
Commercial Insurance	Insurance coverage that isn't maintained or provided by a government run program.
Employer's Liability Insurance (EL)	Provides coverage to the employer for any work related bodily injury or disease aside from the liability that is already imposed on the employees by worker's compensation.
Fiscal Intermediary (FI)	Refers to an entity or a private company that has a contract with CMS to determine and to pay part A and some part B bills, such as bills from hospitals, on a cost basis and to perform other related functions.
Health Maintenance Organization (HMO)	Tend to be more affordable, with less coverage and more restrictions when compared to a PPO.

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HETS (HIPAA Eligibility Transaction System)	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.
Medicaid	A healthcare program that supports low-income families or individuals.
Medicare	The United States federal government health insurance program for Americans who are 65 years of age or older or individuals on disability.
Medicare Coinsurance Days	Hospitalization between day 61-90 days, patient is responsible for part of these costs.
Medigap	Supplemental health insurance for Medicare
Preferred Provider Organization (PPO)	A medical care arrangement in which medical professionals and facilities provide services to subscribed clients at reduced rates. Tend to be more flexible and provide greater coverage but usually have a higher premium and deductible.
Protected Health Information (PHI)	PHI is any information in a medical record that can be used to identify an individual.
Return To Provider (RTP)	Method where Medicare signals back to provider that they are going to reject, and therefore, allows the opportunity to fix before final adjudication.
Self-Pay	A term used to describe someone who chooses to pay for their treatment directly rather than using private health insurance.
Shadow Claim	Synonymous with “Information Only” claim. Submitted to the MAC for Medicare Part A services provided to Medicare Advantage beneficiaries.

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ADMITTING TERMS

Advanced Beneficiary Notification (ABN)	Also known as a waiver of liability, is a notice a provider should give you before your receive a service.
Eligibility	The process of identifying and confirming coverage.
Guarantor	A responsible party and/or insured party who is not necessarily the patient.
Point of Service (POS)	A type of managed care plan that is a hybrid of HMO and PPO plans.
Pre-Certification	Sometimes required by patient's insurance company to determine medical necessity, does not guarantee benefits will be paid.
Subscriber	Medical billing term to describe the employee for group policies.
Treatment Authorization Request (TAR)	A form needed to pre-approved funding for non-standard treatements.

BILLING AND REVENUE CYCLE TERMS

Hospital Billing Terms

Aged Trial Balance (ATB)	Alphabetical list of accounts receivable with outstanding balances.
Bill Hold Days	Hospitals will hold a bill for a period of 3-7 days to allow departments to get their charges in.
Discharge Not Final Billed (DNFB)	Bills that have completed service but have not been billed to insurance yet.
In house	Charges accumulating on a patient's claim who is still receiving inpatient services and hasn't been discharged.
Unbilled A/R	Tracking of dollars not yet submitted to payers. Claims are tracked to make sure they are submitted to meet filing requirements, measured by how many "days" of revenue are sitting in the total unbilled.

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Revenue Cycle Metrics

Aging over 90 days	Total accounts receivable (A/R) dollars unpaid over 90 days. Goal should be to keep A/R aging over 90 days goal at <15%.
Bad Debt	Debt that cannot be collected from patients. It is typically written off and sent to a collection agency. *Goal should be to keep bad debt write-offs under 5%.*
Clean Claim Rate (or validation rate)	A clean claim is a submitted claim which has no defect or special circumstances and a timely payment.
Denial Rate	A denial rate can be calculated by taking the total dollar amount of claims that have been denied by payers within a given time period and then dividing by the total dollar amount of claims submitted within the same time period.
Gross Days Revenue (or receivables) Outstanding (GDRO)	The average number of days that receivables remain outstanding before they are collected. *Goal to have is GDRO < 40 days*

CLAIM FORMS

CMS 1500	Professional paper claim form
Explanation of Medicare Benefits (EOMB or EOB)	Explanation of Medicare Benefits. A notice you receive from Medicare explaining the benefits received and not received.
UB04	The standard claim form that any institutional provider can use for the billing of medical claims.

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FILE TYPES

271	Allows healthcare providers to create HIPPA-compliant files requesting eligibility details for a patient.
275	Contains information regarding the Patient Information Transaction set.
276	Inquiry transaction about a claim.
277	Claims acknowledgement from an inquiry.
5010	HIPPA electronic transaction standards, replaced 4010
824	Transaction set is the electronic version of an Application Advice document. Used to notify the sender of a previous transaction that the document has been accepted, or to report on errors.
835	Provides claim payment informaition back to provider.
837I	File with Institutional claims sent to a payer.
837P	File with Professional claims sent to a payer.
CRD	File returned to Epic.

INDUSTRY ASSOCIATIONS

AAHAM	American Association of Healthcare Administrative Management
AHIMA	American Health Information Management Association
HFMA	Healthcare Financial Management Association
MGMA	Medical Group Management Association

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CODING TERMS

Claim Adjustment Segment (CAS)	Used to report prior payers claim level adjustments that caused the amount paid to differ from the amount originally charged.
Correct Coding Initiative (CCI)	Provides the correct coding methodologies for Medicare Part B claims. Managed by the Centers for Medicare and Medicaid Services (CMS).
Chargemaster (CDM)	Listing of every item, service or procedure that a hospital could provide.
Day Sheet	Summary of daily patient treatments, charges and payments received.
Durable Medical Equipment (DME)	Medical equipment that provides therapeutic benefits to a patient in need.
Evaluation and Management (E/M)	Medical coding process in support of medical billing.
Explanation of Benefits (EOB)	Statement from a health insurance company to covered individuals explaining what medical treatments and/or services were paid on their behalf.
Fiscal Intermediary Standard System (FISS)	Standard Medicare Part A claims processing system.
Healthcare Common Procedure Coding System (HCPCS)	A set of standardized code sets necessary for Medicare and other health insurance providers to provide healthcare claims that are managed consistently and in an orderly manner.
ICD 10	The 10th revision of the International Statistical Classification of Diseases and Related Health Problems, a medical classification list by the World Health Organization
Local Coverage Determination (LCD)	Editing system from CMS that provides decisions on whether a particular service or item is reasonable and necessary and therefore covered by Medicare.

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Medicare Administrative Contractor (MAC)	A private healthcare insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) bendficiaries.
Medical Record Number (MRN)	Unique number that identifies the patient's medical record.
National Coverage Determination (NCD)	Nationwide determination of whether Medicare will pay for an item or service.
National Drug Code (NDC)	A unique 10-digit, 3 segment numeric identifier assigned to each medication listed in the Federal Food, Drug, and Cosmetic Act.
Not Elsewhere Classified (NEC)	Used when the information in the medical record provides detail for a code not listed in ICD-10 an the requires the provider to enter a more generalized code.
National Provider Identifier (NPI)	10-digit provider id number.
Outpatient Code Editor (OCE)	Editing system crated and maintained by CMS to process outpatient facility claims.
Primary Care Network (PCN)	A network of primary care doctors who make provisions for medical care to individuals covered by a specific health plan.
Provider Transaction Access Number (PTAN)	Sometimes called the provider number, Medicare PIN or Medicare ID number. The PTAN is used for Medicare enrollment.
Revenue Codes	4-digit code used on UB04 to provide insurance company with the type of service and location of procedure
Signature on File (SOF)	A patient's official signature on file for the purpose of billing and claims processing.
Superbill	Bill that uses several commonly used ICD-10 codes for reflecting rendered services. It is the main data source for the creation of a healthcare claim.

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Tax Identification Number (TIN)	An identifying number used for tax purposes in the United States. Is used as part of a claim detail record.
Type of Services (TOS)	Old abbreviation used on the old CMS-1500. It is no longer used on the new CMS-1500.

Other Helpful Terms to Know

Department of Health and Human Services (DHHS)	National agency with a mission of enhancing the health and well-being of all Americans.
EMTALA Regulation	A federal law that requires hospitals emergency departments to medically screen every patient who seeks emergency care regardless of health insurance
National Government Services (NGS)	Provides customized health solutions for government agencies.
Officer of Inspector General (OIG)	Part of DHHS and is charged with identifying and combating waste, fraud and abuse in HHS's programs.

Did we miss something or is there another healthcare billing term you are struggling to find a definition for? Let us know via email at efficientC@os-healthcare.com with the title "Revenue Cycle Matters: Healthcare Billing Terminology". We'll do our best to find an answer for you and keep this cheat sheet updated!