The RCM Guy's 450 Most Important Terms for Revenue Cycle Management

Term	Definition
ABN	The advanced beneficiary notice (ABN) is a notice given to patients to convey that the payer is not likely to provide coverage in a specific case. Although the ABN originated in Medicare, many commercial payers have instituted their own ABN policies and forms.
Acceptance Rate	The percentage of claim transactions that are accepted into a payer's system.
Access	The ability of a patient to obtain medical care.
Account	Your charges for a medical visit.
Account Number	Number you're given by your doctor or hospital for a medical visit.
Accountable Care Organization (ACO)	A recognized legal entity under State law and is comprised of a group of participants (providers of services and suppliers) that have established a mechanism for shared governance and work together to coordinate care for Medicare fee-for-service beneficiaries. ACOs enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) to be accountable for the quality, cost, and overall care of traditional fee-for-service Medicare beneficiaries who may be assigned to it.
Accounts receivable (days)	A measure of the efficiency of the collections function. (net patient accounts receivable x 365) ÷ net patient revenue
Accreditation	A process of evaluation for determining the degree of compliance to a set of standard set by a range of stakeholders.
Actual Charge	The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount an insurance plan approves.
Adjudication	The process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.
Adjustment	The portion of your bill that your doctor or hospital has agreed not to charge you.
Admission Date (Admit Date)	Date you were admitted for treatment.
Admission Hour	Hour when you were admitted for inpatient or outpatient care.
Admitting Diagnosis	Words that your doctor uses to describe your condition
Advance Beneficiary Notice (ABN)	A notice the hospital or doctor gives you before you're treated, telling you that Medicare will not pay for some treatment or services. The notice is given to you so that you may decide whether to have the treatment and how to pay for it.
Advance Directive (Healthcare)	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.
Affordable Care Act	Commonly referred to as the Affordable Care Act. Puts in place comprehensive health insurance reforms aim to hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans.
Affordable Insurance Exchange	State-based competitive marketplaces where individuals and small businesses can purchase affordable private health insurance.
Age Restriction	Limitation of benefits when a patient when a patient reaches a certain age.
Age/Sex Rating	Structuring payments based on members' ages and genders.
Aggregate Amount	The maximum for which a member is insured for any single event.
All-inclusive Rate	Payment covering all services during a hospital stay.
Allowable Costs	Charges for services rendered or supplies furnished, by any health care provider, which qualify as covered expenses.
Ambulatory Care	All types of health services that do not require an overnight hospital stay.
Ambulatory Payment Classifications (APC)	A Medicare payment system that classifies outpatient services so Medicare can pay all hospitals the same amount.
Ambulatory Surgery	Outpatient surgery or surgery that does not require an overnight hospital stay.

American Medical Association (AMA)	A nationwide non-profit organization of physicians whose goals are to promote the art and science of medicine and the betterment of public health.
American Recovery and Reinvestment Act of 2009 (ARRA)	The American Recovery and Reinvestment Act of 2009, abbreviated ARRA, commonly referred to as the Stimulus or The Recovery Act, was enacted February 2009. This act made supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and State and local fiscal stabilization. As part of ARRA, Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH) addresses the privacy and security concerns associated with the electronic transmission of health information.
Amount Charged	How much your doctor or hospital bills.
Amount Not Covered	What your insurance company does not pay. It includes deductibles, co-insurances, and charges for non-covered services.
Amount Paid	The dollar amount that you paid for your doctor or hospital visit.
Amount Payable by Plan	How much your insurer pays for your treatment, minus any deductibles, coinsurance, or charges for non-covered services.
Ancillary Service	Services you need beyond room and board charges, such as laboratory tests, therapy, surgery and the like.
Anesthesia	Drugs given to you during surgery to eliminate or reduce surgical procedure pain.
Appeal	A process by which you, your doctor, or your hospital can object to your health plan when you disagree with the health plan's decision to not pay for your care.
Appeal	A specific request to reverse a denial or adverse coverage or payment decision and potential restriction of benefit reimbursement.
Applied to Deductible	Portion of your bill, as defined by your insurance company, that you owe your doctor or hospital.
Appropriateness of Care	Term used to denote proper setting of medical care that best meets the patient's diagnosis.
Approved Charge	The maximum fee a payer will pay in a given geographic area for a covered service.
ASC X12	Accredited Standards Committee X12, chartered by the American National Standards Institute (ANSI), which develops and maintains uniform industry standards for the electronic exchange of business documents. ASC X12N is the Insurance Subcommittee and Task Group 2 specifically addresses healthcare EDI and HIPAA transactions.
Assignment of Benefits	Claimant request for payment of benefits directly to the provider of the services rather than to the member who received the benefits.
Assignment	An agreement you sign that allows your insurance to pay the doctor or hospital directly.
Assignment	An arrangement in which the provider submits the claim on behalf of the patient and is reimbursed directly by the patient's plan.
Assignment of Benefits	When insurance payments are sent directly to your doctor or hospital.
Attained Age	The age of the member as of the last birthday.
Attending Physician Name	The doctor 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.
Authorized User	Users who are permitted to access specific services or data based on their approved credentials.
Automated Clearing House (ACH)	The ACH system is the primary electronic funds transfer (EFT) system used by agencies to make payments.
Average Age of Plant (years)	Indicates the financial age of the fixed assets of the hospital. The older the average age, the greater the short term need for capital resources. accumulated depreciation ÷ depreciation expense

Average Length of Stay (days)	The average stay counted by days of all or a class of inpatients discharged over a given period. Used as an indicator of efficiency in containing inpatient service costs. patient days ÷ total discharges
Average Payment Period (days)	A measure of how efficiently an organization pays its bills. (total current liabilities x 365) ÷ (total operating expenses – depreciation and amortization expenses)
Balance Bill	How much doctors and hospitals charge you after your health plan, insurance company, or Medicare have paid its approved amount.
Balance Billing	Arrangement where a health care provider may bill a covered for charges above the amount reimbursed by the plan. (i.e. the difference between billed charges and the amount paid)
Basic Coverage	Insurance providing coverage for care.
Batch Transactions	One or more transactions that are received, and gathered, possibly during different sessions, and processed in one batch. Batch jobs are set up to be run to completion without manual intervention, so all input data is preselected through scripts or command-line parameters. A program takes a set of data files as input, processes the data, and produces a set of output data files. This operating environment is termed as "batch processing" because the input data are collected into batches of files and are processed in batches by the program.
Beneficiary	Person designated by an insurance company as eligible to receive insurance benefits.
Beneficiary Eligibility Verification	A way for doctors and hospitals to get information about whether you have insurance coverage.
Beneficiary Liability	A statement that you are responsible for some treatments or charges.
Benefit	The amount your insurance company pays for medical services.
Benefit Package	Coverage and reimbursement for health care services a insurance company offers to a group or individual under the terms of the contract.
Benefit Period	The method Medicare uses to measure the use of hospital and skilled nursing facilities. The benefit period starts the day the patient is admitted to the facility and ends when the patient has not received care for 60 days in a row.
Bill Review	The third party review of medical bills for excessive or inappropriate charges.
Bill/Invoice/Statement	Printed summary of your medical bill.
Billed Claims	The fees for health care services provided to a covered person and submitted by a health care provider.
Breach	A breach is, generally, an impermissible use or disclosure under the HIPAA Privacy Rule that compromises the security or privacy of the protected health information (PHI) such that the use or disclosure poses a significant risk of financial, reputational, or other harm to the affected individual. There are three exceptions to the definition of “breach”: The first exception applies to the unintentional acquisition, access, or use of protected health information by a workforce member acting under the authority of a covered entity or business associate. The second exception applies to the inadvertent disclosure of protected health information from a person authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information (PHI) at the covered entity or business associate. In both (of these first two) cases, the information cannot be further used or disclosed in a manner not permitted by the Privacy Rule. The final exception to breach applies if the covered entity or business associate has a good faith belief that the unauthorized individual, to whom the impermissible disclosure was made, would not have been able to retain the information.
Bundling	Packaging together costs or services that might otherwise be billed separately.

Business Associate (BA)	The HITECH Act explicitly places the same comprehensive Security Rule requirements on Business Associates (Bas) as is required of covered entities. - A business associate is a person or entity who provides certain functions, activities, or services for or to a covered entity, involving the use and/or disclosure of PHI. - A business associate is not a member of the health care provider, health plan, or other covered entity's workforce. Examples include billing services, transcription services, practice management, data centers, customer service organizations, and utilization review services. - A health care provider, health plan, or other covered entity can also be a business associate to another covered entity. - The rule includes exceptions. The business associate requirements do not apply to covered entities that disclose PHI to providers for treatment purposes – for example, information exchanges between a hospital and physicians with admitting privileges at the hospital.
Business Associate Agreement (BAA) (Contract)	A contract between the covered entity and its business associate and must contain the elements specified at 45 CFR 164.504(e). For example, the contract must: Describe the permitted and required uses of protected health information by the business associate; Provide that the business associate will not use or further disclose the protected health information other than as permitted or required by the contract or as required by law; and Require the business associate to use appropriate safeguards to prevent a use or disclosure of the protected health information other than as provided for by the contract.
Business Day	The period of time from the opening to the closing of business on a given day. Also refers to any day of the week on which business is typically conducted, namely Monday through Friday with the exception of federal or company holidays.
Business Hours	Published hours in which business is commonly conducted by the organization including standard customer support hours.
Cafeteria Plan	A benefit by an employer where various services of many payers are offered to members as separate elements in the health care plan.
CAGC	The claim adjustment group code (CAGC) is a code that identifies the general category of adjustment made to the claim or service line: Patient responsibility, Contractual obligation, Payer initiated, Corrections/reversals, or Other adjustments.
Calendar Year	January 1 through December 31 of the same year.
Capital expense (%)	A measure of the capital structure and the degree of flexibility an organization might have in raising capital. (interest expense + depreciation & amortization expenses) ÷ total operating expenses
Capitation	A stipulated dollar amount established to cover the cost of health care delivered to a person. A negotiated per capita rate to be pre-paid to a health care provider.
CARC	The claim adjustment reason code (CARC) is a code that indicates the reasons that the payer made the adjustment or denial. If the payer does not report a CARC on the ERA, this indicates that no adjustment was made.
Cardiology Charges	Charges for heart procedures. Examples are heart catheterization and stress testing.
Carrier	An entity that underwrites administers or sells a range of health benefit programs. Often used to refer to a given insurance company.
Carve-out	Medical benefits for a specific type of care not provided by the carrier of the member's insurance.
Case Management	A way to help you get the care you need, especially when you need pre-authorized care from several services. Usually a nurse helps arrange for your care.
Case Management	The management process of identifying patient with specific needs and interacting with them and their providers to assist and coordinate treatment plans for optimal health outcomes.

Case Manager	A clinical professional tasked with working with patients, health care providers and payers to determine and coordinate treatment plans for optimal health outcomes. Sometime referred to as care coordinators.
Cash on Hand (days)	This solvency indicator measures the number of days an organization could pay its cash operating expenses if none of the accounts receivable were collected. This liquidity indicator shows the minimal survival period of an organization. [(cash and cash equivalents + board designated funds for capital) x 365] ÷ (total operating expenses – depreciation and amortization expenses)
Centers for Medicare & Medicaid Services (CMS)	A branch of the U.S. Department of Health and Human Services. CMS is the federal agency that administers the Medicare program and monitors the Medicaid programs offered by each state.
Centers for Medicare and Medicaid (CMS)	The federal agency that runs the Medicare program. In addition, 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.
Certificate of Coverage	The benefits included in a individual's health plan.
Certification	Approval by a payer's case manager to continue care for a given number of days or visits.
CHAMPUS	Insurance linked to military service, also known as TriCare.
Charity Care	Free or reduced-fee care for patients who have financial hardship.
Check 21 Act	A US federal law enacted in October of 2003. The law allows the recipient of the original paper check to create a digital version of the original check (called a "substitute check"), thereby eliminating the need for further handling of the physical document.
Claim	A common term used for a Medical Bill.
Claim	Your medical bill that is sent to an insurance company for processing.
Claim Lag	The time between the incurred date of the claim and its submission. Sometimes refers to the time between the incurred date of the claim and its payment.
Claim Manual	The administrative guidelines used by claims processors to adjudicate claims according to company policy and procedure.
Claim Number	A number given to a medical service.
Claims Manager	The payer's manager who oversees the employee who processes routine claims.
Claims Reviewer	The payer's employee who reviews claims for coding, prior authorization, contract violations, etc.
Clean Claim	A claim that does not have to be investigated by insurance companies before they process it.
Clearinghouse	An entity, either independent or a division of a parent corporation, that processes or facilitates processing of electronic transactions, in standard or nonstandard formats, between two or more trading partners in the healthcare community. (typically insurance claims)
Clinic	An area in a hospital or separate building that treats regularly scheduled or walk-in patients for non-emergency care.
Closed Claim	A claim for which all apparent benefits have been paid.
CMS-1500	Universal claim form developed by the Centers for Medicare and Medicaid Services.
COBRA Insurance	Health insurance that you can buy when you lose your job. It is generally more expensive than insurance provided through your job but less expensive than insurance purchased on your own when you are unemployed.
Code Set	Any set of codes together with the descriptors of the codes that is used to encode data elements, tables of terms, medical concepts, diagnostic codes, or medical procedures. Examples include ICD-9-CM, CDT, CPT, and HCPCS.
Coding of Claims	Translating diagnoses and procedures in your medical record into numbers that computers can understand.
Coinsurance	The cost sharing part of your bill that you have to pay.
Coinsurance	The percentage of plan allowance member must pay their providers for care. Also, the percent of the Medicare-approved amount that is paid after the deductible is met.

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	A business that collects money for unpaid bills.
Commercial Carriers	For-profit insurance companies.
Committee on Operating Rules for Exchange (CORE)	The Committee on Operating Rules for Exchange (CORE), supported by the Council for Affordable Quality Healthcare (CAQH), develops operating rules that direct implementation and use of primarily financial and business administrative data across all stakeholders including providers, clearinghouses, and payers.
Comorbidity	Preexisting condition that causes an increase in the length of stay by at least one day in 75% of cases. For DRG reimbursement.
Concurrent Review	Medical management process of evaluating ongoing case services provided to a patient in accordance with the benefit plan.
Consent (for treatment)	An agreement you sign that gives your permission to receive medical services or treatment from doctors or hospitals.
Consumer	User of healthcare services.
Consumer Engagement	The act of consumers taking an active role in their own health care, from understanding their own conditions and available treatments, to seeking out and making decisions based on information about the performance of health care providers.
Continuity of Coverage	Transfer of benefits from one plan to another without a lapse of coverage.
Contractual Adjustment	A part of your bill that your doctor or hospital must write off (not charge you) because of billing agreements with your insurance company.
Coordination of Benefits (COB)	A way to decide which insurance company is responsible for payment if you have more than one insurance plan.
Co-pay	Agreed amount of the charges for medical services that patients or guarantors must pay.
Co-payment	A cost-sharing arrangement in which a covered person pays a specified charge for a specified service. (ex. $20 for an office visit)
Coronary Care	Routine charges for care you receive in a heart center because you need more care than you can get in a regular medical unit.
Council for Affordable Quality Healthcare (CAQH)	CAQH is a nonprofit alliance of health plans and trade associations that collaborate on initiatives that simplify healthcare administration. The collaborative solutions promote quality interactions between plans, providers and other stakeholders; reduce costs by eliminating unnecessary interaction with healthcare administration; facilitate administrative healthcare information exchange and encourage administrative and clinical data integration.
Covered Benefit	A health service or item that is included in your health plan, and that is paid for either partially or fully.
Covered Charges	Charges for medical care and supplies that will be paid for by an insurance plan.
Covered Days	Days that your insurance company pays for in full or in part.
Covered Person	Person entitled to benefits under the policy, whether a member or a dependent.
CPT Codes	A coding system used to describe what treatment or services were given to you by your doctor.
CT Scan	A type of X-ray of the head or body; usually done in a hospital's x-ray department.
Current ratio (x)	This liquidity indicator shows the number of times short-term obligations can be met from short-term creditors. Because it provides an indication of the ability to pay liabilities, a high ratio number is one way short-term creditors evaluate their margin of safety. total current assets ÷ total current liabilities

Cushion ratio (x)	A measure of the capital structure of the organization. This ratio is important in evaluating the financial risk position of an organization. (cash and cash equivalents + board designated funds for capital) ÷ estimated future peak debt service
Daily Benefit	A specified maximum benefit payable for room and board charges at a hospital.
Data Use Agreement	An agreement between a Covered Entity and a recipient of a limited data set (as described 45 CFR § 164.514(e)(1)) that provides that the limited data set recipient will only use or disclose the limited data set for specified purposes and further provides assurances: (i) prohibiting other uses or disclosures and requiring reports of unauthorized uses or disclosures; (ii) requiring the use of appropriate safeguards; (iii) requiring agents and subcontractors to abide by the same restrictions as the recipient; and, (iv) prohibiting identifying the limited data sets or contacting persons identified by the limited data set.
Date of Bill	The date the bill for your services is prepared. It is not the same as the date of service.
Date of Service (DOS)	The date(s) when you were treated.
Days	The total number of days that you are being charged for the hospital's services.
Debt service coverage ratio (x)	A ratio that measures the organization's ability to meet its debt repayments. A declining ratio number can indicate that an organization is in danger of becoming insolvent. net revenue available for debt service ÷ (principal payment + interest expense)
Debt-to-capitalization (%)	A measure of the long-term sources of debt financing. long-term debt ÷ (long-term debt + unrestricted fund balance)
Deductible	How much cost sharing that you must pay for medical services often before your insurance company starts to pay.
Description of Services	Tells what your doctor or hospital did for you.
Diagnosis Code	A code used for billing that describes your illness.
Diagnosis-Related Groups (DRGs)	A payment system for hospital bills. This system categorizes illnesses and medical procedures into groups for which hospitals are paid a fixed amount for each admission.
Digital Signature	An electronic signature based upon cryptographic methods of originator authentication, computed by using a set of rules and parameters such that the identity of the signer and the integrity of the data can be verified.
Discharge Hour	Hour when you were discharged.
Disclosure	The release, transfer, provision of, access to, or divulging in any other manner, of information outside the entity with the responsibility for holding the information.
Disclosure Log	A log of disclosures that may include timestamp, the identity of the user, an index referencing the data disclosed, and purpose.
Discount	Dollar amount taken off your bill, usually because of a contract with your hospital or doctor and your insurance company.
DOS	Date of service: The date on which the medical service was provided.
Drug Enforcement Administration (DEA)	The Drug Enforcement Administration (DEA) enforces the controlled substances laws and regulations of the United States
Drugs/Self Administered	Drugs that do not require doctors or nurses to help you when you take them. You may be charged for these. You will need to check with your doctor or hospital regarding their policy on this.
Due from Insurance	How much money is due from your insurance company.
Due from Patient	How much you owe your doctor or hospital.
Duplicate Coverage Inquiry	Request made to insurance companies or providers to determine if other medical coverage exists under another plan.
Durable Medical Equipment (DME)	Medical equipment that can be used many times, or special equipment ordered by your doctor, usually for use at home.

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 doctor's reading of the results.
Electronic Data Interchange (EDI)	The computer-to-computer exchange of information in a standard electronic format.
Electronic Health Record (EHR)	An electronic version of a patient's medical history, that is maintained by one or more providers over time, and may include all of the key administrative and clinical data relevant to that person's care under each provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports The EHR automates access to information and has the potential to streamline the clinician's workflow. The terms EHR and EMR are frequently used interchangeably.
Electronic Healthcare Network (EHN)	An entity, either independent or a division of a parent corporation, that processes or facilitates processing of electronic transactions, in standard or nonstandard formats, between two or more trading partners in the healthcare community. (typically insurance claims)
Electronic Media	Electronic storage and transmission media. Electronic storage media include computer hard drives, magnetic tape or disk, optical disk. Electronic transmission media include the Internet, extranet, leased lines, and dial-up lines. Facsimile and voice transmission are not considered electronic media under HIPAA.
Electronic Medical Record (EMR)	An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one healthcare organization. The terms EHR and EMR are frequently used interchangeably.
Eligible Payment Amount	Those medical services that an insurance company pays for.
Eligible Transaction	A transaction which parties have agreed to exchange electronically. As required by HIPAA, the Secretary of Health and Human Services is adopting standards for the following administrative and financial health care transactions: 1. Health claims and equivalent encounter information. 2. Enrollment and disenrollment in a health plan. 3. Eligibility for a health plan. 4. Health care payment and remittance advice. 5. Health plan premium payments. 6. Health claim status. 7. Referral certification and authorization. 8. Coordination of benefits
Emergency Care	Care given for a medical emergency when you believe that your health is in serious danger when every second counts.
Emergency Room	A special part of a hospital that treats patients with emergency or urgent medical problems.
Encounter	Face to face meeting between a patient and a health care provider.
Encryption	The transformation of plain text into cipher text making it unintelligible to anyone except those possessing special knowledge, usually referred to as a key. Encryption provides protection of data during storage and/or transmission.
Enrollee	A person who is covered by health insurance.
Episode of Care	The rendering of health care services during a period of relatively continuous care by a health care facility or provider.
e-Prescribing	The electronic submission of a provider's prescription to a pharmacy.
Established Patient	Individual who has received services from the physician or same specialty from the same group within the past three years.
Estimated Amount Due	How much the doctor or hospital estimates you or your insurance company owes.
Estimated Insurance	Estimated cost paid by your insurance company.
Excess margin (%)	This measure goes beyond the operating margin to include all sources of income and expenses. Other sources of income besides those from patient care operations have become increasingly important to hospitals. (total operating revenue – total operating expenses + non-operating revenue) ÷ (total operating revenue + non-operating revenue)

Exclusion	Specific conditions listed in the contract or health plan for which the policy or plan will not provide coverage.
Explanation of Benefits (EOB/EOMB)	The notice you receive from your insurance company after getting medical services from a doctor or hospital. It tells you what was billed, the payment amount approved by your insurance, the amount paid, and what you have to pay.
Extension of Benefits	Policy provision that allows coverage to continue past the termination date.
External Cause of Injury Code	A code describing a place or item that may have caused injuries, poisoning, or health problems.
Facility	Building, house or place of patient care.
Fast Batch	A method of processing transactions that is distinct from traditional batch methods. With traditional batch methods, processing events are typically scheduled times of day (e.g., collect transactions until a particular time of day and then process all received to that point at a particular time). Fast batch, on the other hand, can mean: 1. As soon as a batch of transactions is received, forward that batch through the various processes without waiting, regardless of the batch being as small as even a single transactions; or 2. (2) After receiving a batch of transactions, process each transaction within that batch in a real-time manner through the remainder of the processes.
Federal Tax ID Number	A number assigned by the federal government to doctors and hospitals for tax purposes.
Fee Maximum	The maximum amount a participating provider may be paid by a plan for a specific health care service.
Fee-for-service	Traditional health care payment system that provides providers with a payment that does not exceed their billed charge for each unit of service.
Financial Responsibility	How much of your bill you have to pay.
Fiscal Intermediary (FI)	A Medicare agent that processes Medicare claims.
Formulary	List of prescription drugs covered by a particular drug benefit plan. Formularies are based on evaluations of efficacy, safety, and cost-effectiveness of drugs. Patients pay varying co-pays for drugs that are on formulary. For drugs that are not on formulary, patients must pay the entire cost of the drug. Formularies vary between drug plans and differ in the breadth of drugs covered and costs of co-pay and premiums. Most formularies cover at least one drug in each drug class, and encourage generic substitution. Also known as a preferred drug list.
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.
Gatekeeper	Practice where a primary care physician must provide a member's care unless the patient is referred to a specialist.
Grace Period	Set number of days past the due date of a premium payment during which medical may not be cancelled and the premium payment may be made.
Grievance	Issue or concern expressing dissatisfaction with products, services, operations and/or protocol on behalf of a customer.
Guarantor	Someone who has agreed to pay the bill.
HCFA 1500 Billing Form (CMS)	A form used by doctors to file insurance claims for medical services.
HCPC Codes	A coding system used to describe what treatment or services were given to you by your doctor.
HCPCS	The Healthcare Common Procedure Coding System (HCPCS, often pronounced by its acronym as "hick picks") is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).
HCPCS Modifiers	Modifiers are two digit numeric or alphanumeric characters that are appended to CPT and HCPCS Level II codes. A modifier provides a means to indicate that a service or procedure was altered by specific circumstances, without changing the definition of the code.

Health Care Financing Administration (HCFA)	Former name of the government agency now called the Centers for Medicare & Medicaid Services.
Health Insurance	Coverage that pays benefits for sickness or injury. It includes insurance for accidents, medical expenses, disabilities, or accidental death and dismemberment.
Health Maintenance Organization (HMO)	An insurance plan that pays for preventive and other medical services provided by a specific group of participating providers.
Health Plan	An individual or group plan that provides, or pays the cost of, medical care.
Healthcare Provider	Someone who provides medical services, such as doctors, hospitals, or laboratories. This term should not be confused with insurance companies that "provide" insurance.
HHS	The U. S. Department of Health & Human Services.
HIPAA	The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health & Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for physicians and other health care professionals, health insurers and employers. HIPAA also addressed the security and privacy of health data.
HIPAA non-privacy complaint form	The Office of E-Health Standards and Services (OESS) in the Centers for Medicare & Medicaid Services (CMS), the federal agency responsible for overseeing the non-privacy provisions of the Administrative Simplification Act, will use a complaint-driven approach for enforcement. Visit www.cms.hhs.gov/enforcement/downloads/complaintinwriting.pdf to view the written HIPAA non-privacy complaint form. Visit https://htct.hhs.gov/aset/ to access CMS' electronic tool for complaints.
HITECH	The Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of health information technology.
HL7	Health Level 7 – An ANSI standards development organization (SDO) that focuses on clinical and administrative transactions.
Home Health Agency	An agency that treats patients in their homes.
Hospice	Group that offers inpatient, outpatient, and home healthcare for terminally ill patients.
Hospital Inpatient Prospective Payment System (PPS)	A federal system that pays a fixed fee for inpatient care.
ICD-10	ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).
ID Card	The wallet card carried by the patient member providing, name, member number, group number, effective dates, deductibles, and other information.
In Plan	Services chosen from a provider that is within the insurance plan's network.
Incremental Nursing Charge	Charges for nursing services added to basic room and board charges.
Indemnity Plan	Insurance plan that reimburses based on billed charges and modified, if necessary, in accordance with reasonable and customary expense guidelines.
Inpatient (IP)	Patients who stay overnight in the hospital.
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.

Intermediary	An intermediary is: “a third party who facilitates a deal between two other parties”. Widely used in financial services, a financial intermediary is: “a financial institution that connects surplus and deficit agents”. As used in an e-prescribing context, an intermediary means any technology system that receives and transmits an electronic prescription between the practitioner and the pharmacy
Internal Audit	In-house review of records system activity and security incidents. Such records might include system logs, file access information, security incident reports, etc.
Internal Control Number (ICN)	A number assigned to your bill by your insurance company or their agent.
International Classification of Diseases, 9th Edition (ICD-9-CM)	A coding system used to describe what treatment or services your doctor gave to you.
IV Therapy	Treatment provided by giving intravenous solutions or drugs.
Labor and Delivery Room	A unit of a hospital where babies are born.
Laboratory	Charges for blood tests and tests on body tissue samples, such as biopsies.
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.
Limiting Charge	The maximum amount a nonparticipating provider can charge for services to a Medicare patient. Also the highest amount of money that can be charged for a covered service by providers who do not accept assignment.
Limits	The ceiling for benefits payable under a plan.
Lockbox	A service offered by banks to companies in which the company receives payments by mail to a post office box from which the bank picks up payments and deposits them into the company's account. Images of the original documents are typically provided to the customers as part of this service. Other services may also be provided such as the submission to the lockbox of images of documents received elsewhere.
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.
Mailer/Summary of Account	A monthly summary of services (and charges?) mailed to the person who pays the bill.
Maintained bed occupancy (%)	A measure of the volume and utilization of inpatient services. (patient days x 100) ÷ (maintained beds x 365)
Managed Care	An insurance plan that requires patients to see doctors and hospitals that have a contract with the managed care company, except in the case of medical emergencies or urgently needed care if you are out of the plan’s service area.
Management Service Organization (MSO)	Organizations that, for a fee, provides physician groups with such management services as group purchasing, billing and other financial activities, and assistance with insurance and staffing issues.
Master Patient Index (MPI)	Master Patient Index (MPI) is a database that maintains a unique index (or identifier) for every patient registered at a health care organization or other entity tracking patient information such as a health information exchange. The MPI is used to ensure a patient is logically represented only once with the same set of registration data. It can also be used as an enterprise tool to assure that vital clinical and demographic information can be cross-referenced between different facilities in a health care system.
Maximum Allowable Charge (MAC)	Amount se by an insurer as the highest amount to be charged for a particular medical service.
Maximum Out-of-Pocket Costs	The limit on total member copayments, deductibles, and coinsurance under a benefit contract.

Meaningful Use	Meaningful use describes the use of health information technology (HIT) that leads to improvements in healthcare and furthers the goals of information exchange among health care professionals. The meaningful use rule is part of a coordinated set of regulations to help create a private and secure 21st-century electronic health information system. To become "Meaningful Users", providers need to demonstrate that they use certified EHR technology in ways that can be measured significantly in quantity and in quality.
Meaningful Use Incentives	The Medicare and Medicaid EHR Incentive Programs will provide incentive payments to eligible providers, professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.
Medicaid	A state administered federal and state funded insurance plan for low-income people who have limited or no insurance.
Medical Bill	A statement of charges for medical services. A medical bill is also called a claim.
Medical Biller	The person or entity responsible for the process of collecting fees for medical services.
Medical Consultation	Advice or an opinion rendered by a physician at the request of the primary care provider.
Medical Necessity	Medical necessity is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
Medical Record Number	The number assigned by your doctor or hospital that identifies your individual medical record.
Medical/Surgical Supplies	Special supplies, such as materials used to repair a wound or instruments used for your care.
Medically Necessary	Services or supplies that: 1. Are proper and needed for the diagnosis or treatment of the medical condition, 2. Are used for the diagnosis, direct care, and treatment of the medical condition, 3. Meet the standards of good medical practice in the local community, 4. Are not mainly for the convenience of the patient or the doctor.
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 that pays for preventive and other healthcare from designated doctors and hospitals.
Medicare Approved	Medical services for which Medicare normally pays.
Medicare Approved Amount	The fee set as reasonable for a covered medical service.
Medicare Assignment	Doctors and hospitals that have accepted Medicare patients and agreed not to charge them more than Medicare has approved.
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 Paid Provider	The amount of your bill that Medicare paid to your doctor or hospital.
Medicare Part A	Usually referred to as Hospital Insurance, it helps pay for inpatient care in hospitals and hospices, as well as some skilled nursing costs.
Medicare Part B	Helps pay for doctor services, outpatient care, and other medical services not paid for by Medicare Part A.
Medicare Secondary Payer (MSP)	Medicare Secondary Payer (MSP) is the term generally used when the Medicare program does not have primary payment responsibility - that is, when another entity has the responsibility for paying before Medicare.
Medicare Summary Notice (MSN)	The notice you receive from Medicare after getting services from your doctor 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).
Medicare Supplement	Private insurance coverage that pay costs of services not covered by Medicare.

Medigap	Medicare Supplement Insurance that pays for some services not covered by Medicare A or B, including deductible and coinsurance amounts.
Member	A subscriber of a health plan.
Member Services	The payer department that works as a patient advocate to solve problems.
Message	In Electronic Data Interchange (EDI), a message contains a string of data elements, each of which represents a singular fact, such as a price, product model number, and so forth, separated by delimiter. The entire string is called a data segment. One or more data segments framed by a header and trailer form a transaction set, which is the EDI unit of transmission (equivalent to a message).
Minor Procedures	Procedures considered by many payers to be part of the package for a primary surgical service.
Modified Fee-for-Service	A system where health care provider are paid on a fee-for-service basis, with certain fee maximums for each procedure.
MRI	A type of X-ray; magnetic resonance brain or body images, usually done in a hospital's x-ray department.
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a 10-digit number used to identify all healthcare providers including individuals (e.g., physicians, nurses, dentists, chiropractors, physical therapists, and pharmacists) or organizations (e.g., hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, HMOs, suppliers of durable medical equipment, and pharmacies. The NPI is used to identify all healthcare providers in HIPAA standard transactions and in patient health records.
National Uniform Billing Committee (NUBC)	The National Uniform Billing Committee (NUBC) was brought together by the American Hospital Association (AHA) in 1975 and includes the participation of all the major national provider and payer organizations. The NUBC was formed to develop a single billing form and standard data set that could be used nationwide by institutional providers and payers for handling health care claims.
National Uniform Claim Committee (NUCC)	The National Uniform Claim Committee (NUCC) is a voluntary organization that replaced the Uniform Claim Form Task Force in 1995. The committee was created to develop a standardized data set for use by the non-institutional health care community to transmit claim and encounter information to and from all third-party payers. It is chaired by the American Medical Association (AMA), with the Centers for Medicare and Medicaid Services (CMS) as a critical partner. The committee is a diverse group of health care industry stakeholders representing providers, payers, designated standards maintenance organizations, public health organizations, and vendors.
Nationwide Health Information Network (NwHIN or NwHIN)	The Nationwide Health Information Network (NHIN), now referred to as NwHIN, a program under the Office of the National Coordinator for Health Information Technology (ONC), was established in 2004 to improve the quality and efficiency of healthcare by establishing a mechanism for nationwide health information exchange. The NwHIN is a set of conventions that provide the foundation for the secure exchange of health information that supports meaningful use. The foundation includes technical, policy, data use and service level agreements and other requirements that enable data exchange, whether between two different organizations across the street or across the country. Participants in the NwHIN agree to support a common set of web services and data content (NwHIN Core Services) that enables private, secure and interoperable communication of health information among NwHIN participants across the public Internet.
Network	A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.
New Patient	Patient who is receiving care from the provider for the first time within three years.
Non-Covered Charges	Charges for medical services denied or excluded by your insurance. You may be billed for these charges.

Non-Participating Provider	A doctor, hospital, or other healthcare provider that is not part of an insurance plan's doctor or hospital network.
Non-Participating Provider (non-par)	A health care provider who has not contracted with the carrier or health plan to be a participating provider of health care.
Notice of Privacy Practices	A detailed statement of policies, practices or procedures by a Covered Entity that explains how a health plan or healthcare provider uses or discloses Protected Health Information and assures the privacy rights of subject individuals.
Nursery	Nursing care charges for newborn babies.
Observation	Type of service used by doctors and hospitals to decide whether you need inpatient hospital care or whether you can recover at home or in an outpatient area. Usually charged by the hour.
Office for Civil Rights (OCR)	The Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.
Office of the National Coordinator for Health Information Technology (ONC)	The Office of the National Coordinator for Health Information Technology (ONC) is the principal Federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The position of National Coordinator was created in 2004, through an Executive Order, and legislatively mandated in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009. ONC is organizationally located within the Office of the Secretary for the U.S. Department of Health and Human Services (HHS).
Oncology	Charges for treating cancer and related diseases.
Open Enrollment Period	Time during which subscribers in a health benefit program have an opportunity to re-enroll or select an alternative health plan being offered to them.
Operating margin (%)	This profitability indicator shows the income derived from patient care operations. Profitability indicators measure the extent to which the organization is using its financial and physical assets to generate a profit. (total operating revenue – total operating expenses) ÷ total operating revenue
Operating Room	A hospital or clinic area where surgeries are done.
Ordering Physician	Provider who orders non-physician services, such as laboratory tests, pharmaceutical services, or durable medical equipment.
Other Party Liability	In coordination of benefits (COBs) the decision that the other plan is the primary plan.
Other Room and Board	Any extra charges that cannot be included in routine room and board charges.
Out of Area (OOA)	Coverage for treatment obtained by a covered person temporarily outside the network service area.
Out of Network (OON)	Coverage for treatment obtained from a non-participating provider.
Out of Plan	Choosing a provider who is not a member of the preferred provider network.
Out-of-Network Provider	A doctor or other healthcare provider who is not part of an insurance plan's doctor or hospital network. Same as non-participating provider.
Out-of-Pocket Costs	Costs you must pay because Medicare or other insurance does not cover them.
Out-of-Pocket Costs	The portion of payments for covered health services required to be paid by the enrollee, including copayments, coinsurance, and deductibles.
Outpatient (OP)	Patient who does not need to stay overnight in a hospital. Outpatient services include lab tests, x-rays, and some surgeries.
Outpatient Service	A service you receive in one day at a hospital or clinic without staying overnight.
Over-the-Counter Drug	Drugs not needing a prescription that you buy at a pharmacy or drug store.

Paid to You	Amount the insurance company pays you or your guarantor.
Participating Provider	A doctor or hospital that agrees to accept your insurance payment for covered services as payment in full, minus your deductibles, co-pays and coinsurance amounts.
Participating Provider	A doctor, hospital, or other health care entity that is part of an insurance plan's network. They agree to accept insurance payment for covered medical services as payment in full, less any patient liability.
Password	A confidential string of characters used to gain access to a computer system or application.
Patient	A person who obtains health care services from a doctor, hospital or other healthcare provider; a user of healthcare services.
Patient Amount Due	The amount charged by your doctor or hospital that you have to pay.
Patient Authorization	A document signed by the patient or their legal representative authorizing the release of specific Protected Health Information.
Patient Centered Medical Home (PCMH)	The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.
Patient Type	A way to classify patients--outpatient, inpatient, etc.
Pay This Amount	How much of your bill you have to pay.
Payer	An organization that pays for health care expense coverage.
Peer Review	A system of evaluation where persons use established standards of business practices to assess the performance of their colleagues.
Per Diem Reimbursement	Reimbursement to an institution based on a set rate per day rather than on a charge by charge basis.
Pharmacy Benefit Manager (PBM)	A company under contract with managed care organizations, self-insured companies, or government programs to manage that organization's drug benefit program. Services may include pharmacy network management, drug utilization review, outcomes management, and disease management.
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 doctor's supervision.
Physician Office	Your doctor's office.
Physician Practice	A group of doctors, nurses, and physician assistants who work together.
Physician Practice Management	Non-physician staff hired to manage the business aspects of a physician practice. These staff include billing staff, medical records staff, receptionists, lab and X-ray technicians, human resources staff, and accounting staff.
PIN	Physician Identification Number
Place of Service	The physical location where health services are rendered (e.g. office, home, hospital, etc.)
PMS	Practice management system: The software or system the physician practice uses for billing.
Point-of-Service Plan (POS)	An insurance plan that allows you to choose doctors and hospitals without having to first get a referral from your primary care doctor.
Policy Number	A number that your insurance company gives you to identify your contract.
PR	Patient responsibility: The patient's financial responsibility for any deductibles, co-insurance or co-payment amounts, or the patient's obligations for payment of non-covered services.

Practice Management System/Software (PMS)	Practice management software (PMS) is a category of software that supports the day-to-day operations of a medical practice. Such software frequently allows users to capture patient demographics, schedule appointments, maintain lists of insurance payers, perform billing tasks, and generate reports. PMS is often connected to an electronic medical records (EMR) system. While some information in a PMS and an EMR overlaps — for example, patient and provider data — in general the EMR system is used for the assisting the practice with clinical matters, while PMS is used for administrative and financial matters.
Pre auth, pre-cert	Also referred to as prior authorization, pre-certification or pre-determination. These terms refer to any payer programs that employ prior review of the quality, medical necessity and/or appropriateness of services or the site of services.
Pre-Admission Approval or Certification	An agreement by your insurance company to pay for your medical treatment. Doctors and hospitals ask your insurance company for this approval before providing your medical treatment.
Precertification	Authorization for a specific medical procedure before it is done or for admission to an institution for care.
Pre-Existing Condition	A health condition or medical problem that you already have before you sign up to receive insurance. Some health insurers may not pay for health conditions you already have.
Pre-existing Condition	A pre-existing condition is generally considered an illness or disability a person has prior to applying for health insurance coverage.
Preferred Provider Organization	A preferred provider organization (or PPO, sometimes referred to as a participating provider organization or preferred provider option) is a managed care organization of medical doctors, hospitals, and other health care providers who have agreed with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients.
Preferred Provider Organization (PPO)	A preferred provider organization (or "PPO", sometimes referred to as a participating provider organization or preferred provider option) is a managed care organization of medical doctors, hospitals, and other health care providers who have a covenant with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients
Premium	The amount paid to a carrier for providing coverage under a contract.
Prepayments	Money you pay before getting medical care; also referred to as preadmission deposits.
Presenting Problem	A disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for the patient encounter.
Prevailing Charge	A billing charge that is commonly made by doctors in a specific region or community. Your insurance company determines this charge.
Preventative Services	Care to prevent illness or keep patients healthy.
Primary Care Network (PCN)	A group of doctors serving as primary care doctors.
Primary Care Physician (PCP)	A doctor whose practice is devoted to internal medicine, family/general practice, or pediatrics. Some insurance companies consider Obstetrician/gynecologists primary care physicians.
Primary Coverage	Under coordination of benefit rules, the coverage plan that considers and pays its eligible expenses without consideration of any other coverage.
Primary Diagnosis	The code reflecting the current, most significant reason for the services or procedures provided.
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.
Principal Diagnosis	The condition established after study to be chiefly responsible for occasioning the admission of the patient.
Principal Procedure	The procedure performed for definitive treatment rather than on e performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.
Prior Authorization	The process of obtaining prior approval for health care coverage based on a plan's certificate of coverage.

Privacy Officer or Official	The Privacy Officer or Official is responsible for developing and implementing the privacy policies and procedures for a covered entity. They are also a contact responsible for receiving complaints and providing individuals with information on the covered entity's privacy practices. The Security Officer role and the Privacy Officer role maybe performed by the same person in the organization.
Privacy Rule	Standards for Privacy of Individually Identifiable Health Information, as specified in 45 CFR Parts 160 and 164.
Private Room (Deluxe)	A more expensive hospital room than those available to other patients. You may have to pay extra for this type of room if it is not a medical necessity.
Procedure Code (CPT Code)	A code given to medical and surgical procedures and treatments.
Prospective Payment System (PPS)	A Medicare system that pays hospitals a set amount for covered diagnostic or treatment services.
Protected Health Information (PHI)	PHI is individually identifiable health information: (1) Except as provided in paragraph two (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium. (2) Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer.
Provider	A supplier of healthcare services, supplies, or equipment.
Provider Contract Discount	A part of your bill that your doctor or hospital must write off (not charge you) because of billing agreements with your insurance company.
Provider Name, Address, & Phone #	Name and address of the doctor or hospital submitting your bill.
Psychiatric/Psychological Treatments	Nursing care and other services for emotionally disturbed patients, including patients admitted for inpatient care and those admitted for outpatient treatment.
Qualified Medicare Beneficiary	A person whose income falls below 100% of federal poverty guidelines, for whom the state must pay the Medicare Part B premiums, deductibles and copayments.
Radiology	X-rays used to identify and diagnose medical problems.
RARC	The remittance advice remark code (RARC) is a code that indicates the supplemental, non-financial explanation for an adjustment already described by a CARC. RARCs may include specific information about the patient's insurance policy and may be used in coordination-of-benefits transactions.
Reasonable and Customary	The amount that your health plan determines is the normal range of payment for a specific health-related service or medical procedure within a given geographic area.
Reasonable and Customary (R & C)	Billing charges that insurers believe are appropriate for services throughout a region or community.
Recovery Room	A special room where you are taken after surgery to recover before being sent home or to your hospital room.
Referral	Approval needed for care beyond that provided by your primary care doctor or hospital. For example, managed care plans usually require referrals from your primary care doctor to see specialists or for special procedures.
Referral	An approval from the primary care physician to see a specialist or receive certain services.
Referral Provider	A health care provider who renders a service to a patient who has been referred by a participating provider in the health plan.
Regional Health Information Organization (RHIO)	Organized cross-organizational healthcare data-sharing organizations are referred to as RHIOs. These organizations are also referred to as health information exchanges (HIEs).
Reimbursement	Payment of actual charges incurred as a result of accident or illness.

Reinsurance	Insurance that is purchased by an insurance company from one or more other insurance companies directly or through a broker as a means of risk management, sometimes in practice including tax mitigation and other reasons described below.
Release of Information	A signed statement from patients or guarantors that allows doctors and hospitals to release medical information so that insurance companies can pay claims.
Re-marketing	Selling the services of an Electronic Healthcare Network or VAN to another network, vendor, or other third party that re-sells those services to a customer. Sometimes the services are renamed under a private label agreement.
Renal Dialysis	Removal of wastes from the blood. Normally the kidneys would remove these wastes if they were functioning properly.
Renewal	Continuance of coverage under a policy beyond its original term by the acceptance of a premium for a new policy term.
Resource Based Relative Value Scale (RBRVS)	A fee schedule introduced by CMS to reimburse physician' Medicare fees based on the amount of time and resources expanded in treating patients with adjustments for overhead costs and geographical differences.
Respiratory Therapy	Giving oxygen and drugs through breathing, as well as other therapies that measure inhaled and exhaled gases and blood samples.
Responsible Party	The person(s) responsible for paying your hospital bill--usually referred to as the guarantor.
Retiree Drug Subsidy Program (RDS)	The retiree drug subsidy (RDS) is one of several options available under Medicare that enables employers and unions to continue assisting their Medicare eligible retirees in obtaining more generous drug coverage. It is generally considered the easiest and most straightforward of the available options, and can often be implemented with little or no benefit design changes to current coverage.
Retrospective Review	Determination of medical necessity and/or appropriate billing practice for services already rendered.
Revenue Code	A billing code used to name a specific room, service (X-ray, laboratory), or billing sum.
Rider	Benefits in addition to the basic policy.
Risk	Risk is a function of the likelihood of a given threat triggering or exploiting a particular vulnerability, and the resulting impact on the organization. This means that risk is not a single factor or event, but rather it is a combination of factors or events (threats and vulnerabilities) that, if they occur, may have an adverse impact on the organization.
Risk Assessment	A formal process wherein business risk is typically measured using a combination of impact potential and occurrence probability. The risk assessment determines the potential risks and vulnerabilities to the confidentiality, availability and integrity of all PHI that an organization creates, receives, maintains, or transmits. The risk assessment should be reviewed at least annually or when major changes occur in the entity's organization or architecture.
Room and Board Private	Routine charges for a room with one bed.
Room and Board Semiprivate	Routine charges for a room with two beds.
Same-Day Surgery	Outpatient surgery.
Sarbanes Oxley (SOX)	The Sarbanes-Oxley Act, commonly called Sarbanes–Oxley, Sarbox or SOX, is a United States federal law enacted in July 2002 that introduced major changes to the regulation of corporate governance and financial practice.

SAS 70 Audit Statement on Auditing Standards No. 70 Audit	Statement on Auditing Standards (SAS) No. 70, Service Organizations, is a widely recognized auditing standard developed by the American Institute of Certified Public Accountants (AICPA). A service auditor's examination performed in accordance with SAS No. 70 (also commonly referred to as a "SAS 70 Audit") is widely recognized, because it represents that a service organization has been through an in-depth audit of their control objectives and control activities, which often include controls over information technology and related processes. In addition, the requirements of Section 404 of the Sarbanes-Oxley Act of 2002 make SAS 70 audit reports even more important to the process of reporting on the effectiveness of internal control over financial reporting. This standard was replaced by SSAE 16 for all reports after June 2011.
Secondary Care	Services provided by medical specialists, such as cardiologists, urologists and dermatologists who generally do not have first contact with patients.
Secondary Coverage	The plan that has the responsibility for payment of a portion or all of any eligible charges that are not covered by the primary benefit plan.
Secondary Insurance	Extra insurance 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.
Secondary Insurer	In a COB arrangement, the insurer that reimburses for benefits pending after payment by the primary insurer.
Security and Trust Agent (STA)	The security and trust agent is responsible for implementing the policies of the Applicability Statement. It contains interfaces and implementations for resolving private and public certificates, message signing and validating message signatures, message encryption, and enforcing trust policies.
Security Officer or Official	The Security Officer, required by HIPAA's Security Rule, is responsible for the development and implementation of policies and procedures that safeguard electronic protected health information. The Security Officer role and the Privacy Officer role maybe performed by the same person in the organization.
Self-Pay Patients	Patients who pay for medical care out-of-pocket.
Separate Procedures	Services that are commonly carried out as an integral part of a total service, and as such do not warrant a separate identification.
Service Area	Geographic area where your insurance plan enrolls members. In an HMO, it is also the area served by your doctor network and hospitals.
Service Area	The geographic area serviced by the health plan as approved by state regulatory agency.
Service Begin Date	The date your medical services or treatment began.
Service Code	A code describing medical services you received.
Service Date	The date service is rendered to a patient and incurs a charge.
Service End Date	The date your medical services or treatment ended.
Service Level Agreement (SLA)	A formal written agreement made between two parties: the service provider and the service recipient. The SLA defines the basis of understanding between the two parties for delivery of a service.
Sign-in Sheets	Formal documentation whereby a visitor (or patient) signature is required upon their arrival.
Skilled Nursing Facility	An inpatient facility in which patients who do not need acute care are given nursing care or other therapy.
Software as a Service (SaaS)	Software as a service (SaaS), sometimes referred to as "on-demand software," is a software delivery model in which software and its associated data are hosted centrally (typically in the (Internet) cloud) and are typically accessed by users using a web browser over the Internet.
Source of Admission	The source of your admission—referral, transfer, emergency room, etc.

Specialist	A doctor who specializes in treating certain parts of the body or specific medical conditions. For example, cardiologists only treat patients with heart problems.
Standard Transaction	A healthcare transaction that meets HIPAA standards and implementation specifications. HIPAA standard transactions are defined for Healthcare Claims or Encounters, Referral Certification and Authorization, Claims Payment and Remittance Advice, Health Claim Status, Coordination of Benefits, Health Plan Eligibility, Enrollment/Disenrollment in a Health Plan, and Health Plan Premium Payments. HIPAA adopted certain standard transactions for Electronic Data Interchange (EDI) of health care data. These transactions are: claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, and premium payment. Under HIPAA, if a covered entity conducts one of the adopted transactions electronically, they must use the adopted standard.
Stated mission	A brief statement of the purpose of an organization.
Statement Covers Period	The date your services or treatment begin and end.
Statement on Standards for Attestation Engagements (SSAE)16	Statement on Standards for Attestation Engagements (SSAE) No. 16 replaced Statement on Auditing Standards No. 70 (SAS70).
Submitter ID	Identification number (ID) that identifies doctors and hospitals who bill by computers. Doctors and hospitals get an ID from each insurance company to whom they send claims using the computer.
Supplemental Health Services	Optional services that a health plan may cover or provide.
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.
Technical Safeguards	Technology and processes that are put in place to protect electronic Protected Health Information and to control access to it.
Telehealth	The use of telecommunication technologies to provide healthcare services and access to medical and surgical information for training and educating healthcare professionals and consumers, to increase awareness and educate the public about health-related issues, and to facilitate medical research across distances.
Termination Date	The date that a group contract expires; or the date that a subscriber or eligible person ceases to be eligible.
Tertiary Care	Health services provided by highly specialized providers such as neurosurgeons, thoracic, and intensive care units.
Third Party Administrator (TPA)	An organization that processes healthcare claims without carrying insurance risk. Third party administrators have the expertise and capability to administer all or a portion of the claims process. They are normally contracted by a health insurer or self-insuring organization to administer services including claims administration, enrollment, and other administrative activities. A hospital or provider organization desiring to set up its own health plan will often outsource certain responsibilities to a TPA.
Third Party Administrator (TPA)	A person or organization that processes claims and performs other administrative services in accordance with a service contract, usually in the field of employee benefits.
Third-Party Payer	A public or private organization that pays for or underwrites coverage for health care expenses for another entity.
Total Charges	Total cost of your medical services.
Trading Partners	Two or more parties involved in a business relationship.

Transaction	The electronic transmission of information between two parties (trading partners) to carry out financial, administrative, or clinical activities. Also refers to the message communicated between the parties.
Transaction Audit Information	The detailed record or log of a transaction including timestamp of initial receipt, and timestamp of any processes performed on the transaction, and timestamp of transmission to another entity. (See Audit trail)
Transaction Error	An incomplete or inaccurate transaction.
Transmission	Electronic transfer of data.
Turnaround Time	The measure of a process cycle from the date a transaction is received to the date completed. For claims processing, the number of days from the date a claim is received to the date paid.
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.
UB-04	Uniform Billing Code of 2004. The common claim form used by facilities to bill for services.
Unbundling	Separately packaging costs or services that might otherwise be billed together.
Units of Service	Measures of medical services, such as the number of hospital days, miles, pints of blood, kidney dialysis treatments, etc.
Up-coding	In claims submission, using a higher-level procedure code than the level of service actually provided.
UR	Utilization review: Generally refers to retrospective or concurrent review of the quality, medical necessity and/or appropriateness of services or the site of services.
Utilization Review (UR)	Hospital staff who work with doctors to determine whether you can get care at a lower cost or as an outpatient.
Wellness	Wellness is an active process through which people become aware of, and make choices toward, a more successful existence.
Withhold	The at-risk portion of a claim that is deducted and withheld by the health plan before payment is made to a participating physician as an incentive for appropriate utilization and quality of care.
Wraparound Plan	Insurance or health plan coverage for co-pays and deductibles not covered under a member's base plan.
You May be Billed	A phrase used by your insurance company informing you that your doctor or hospital may bill some charges directly to you.