BILLING AND CODING COURSE

MIDWIFERY BUSINESS CONSULTATION

MEDICAL BILLING VOCABULARY

HEALTH MAINTENANCE ORGANIZATION (HMO)

A network of healthcare providers that offer coverage to patients for medical services exclusively within that network. We'll cover this type of insurance more thoroughly in later videos.

WA (IN NETWORK NEGOTIATED RATE)

An arrangement between a healthcare provider and an insurance payer that pays the provider a fixed sum for every patient they take on. Capitated arrangements typically occur within HMOs (See "Health Maintenance Organization (HMO)"). HMOs enlist patients to service providers, who are paid a certain amount based on the patient's health risks, age, history, race, etc.

ALLOWED AMOUNT

The amount an insurance company will pay to reimburse a healthcare service or procedure. The patient will typically pay the balance if there is any remainder.

POINT OF SERVICE (POS) PLAN

In this insurance plan, a patient in an HMO network can go to a physician outside of their network if they are referred there and pay a higher deductible. Think of this as a cross between an HMO and basic indemnity insurance

PREFERRED PROVIDER ORGANIZATION (PPO)

A plan similar to an HMO, except that the insurance company, rather than the HMO itself, decides who is in the acceptable provider network. This is a common, subscription-based type of managed care.

COVERED SERVICE

Services or supplies for which your health plan will pay (or “cover”) all or a portion of the cost.

NON-COVERED SERVICE

Services or supplies for which your health plan will not pay (or “not cover”) any of the cost. Most health plans do not cover all services and supplies, and it is important to be aware of any limitations and restrictions that apply to your covered services.

DEDUCTIBLES

The amount you're responsible for paying for covered medical expenses before your health insurance plan begins to pay for covered medical expenses each year.

OUT OF POCKET MAX

The most you will have to pay for covered medical expenses in a plan year through deductible and coinsurance before your insurance plan begins to pay 100 percent of covered medical expenses

CO-PAYMENT

The payment you make, usually a fixed dollar amount such as $15, each time you visit the doctor or fill a prescription medication. Not all plans have copayments. These typically do not accumulate toward the deductible.

CO-INSURANCE

A type of insurance arrangement between the payer and the patient that divides the payment for medical services by percentage. While this is sometimes used synonymously with a co-pay, the arrangements are different: While a co-pay is a fixed amount the patient owes, in a co-insurance, the patient owes a fixed percentage of the bill. These percentages are always listed with the payer’s percentage first (eg a 70-30 co-insurance).

CLEAN CLAIM

A claim received by an insurance payer that is free from errors and processed is a timely manner. Clean claims are a huge boon to providers, as they reduce turnaround time for the reimbursement process and lower the need for time-consuming appeals processes. Many providers send their claims to third parties, like clearinghouses (See “Clearinghouse”), that specialize in creating clean claims.

EXPLANATION OF BENEFITS (EOB)

A document attached to a processed claim that explains to the provider and patient which services an insurance company will cover. EOBs may also explain what is wrong when a claim is denied.

ASSIGNMENT OF BENEFITS (AOB)

Insurance payments paid directly to the healthcare provider for medical services administered to the patient. The assignment of benefits occurs after a claim has been successfully processed.

ELECTRONIC REMITTANCE ADVICE (ERA)

A digital version of the EOB, this document describes how much of a claim the insurance company will pay and, in the case of a denied claim, explains why the claim was returned.