UCLA Health | David Geffen School of Medicine

Office of Compliance Services

Revenue Cycle and Billing Terminology and Definitions

Advance Beneficiary Notice (ABN)	A notice that a provider/physician or supplier should give to a Medicare beneficiary when furnishing an item/service for which Medicare is expected to deny payment.
Adjustment (aka "write off')	A management action to discontinue pursuit of reimbursement or collection. This is usually because the claim filing deadline has passed or there is a billing error that the insurance company will not forgive or reconsider. This action should be carefully considered, as each adjustment negatively impacts the organization's revenue.
Allowed amount	The sum an insurance company will reimburse (allow) to cover a healthcare service or procedure. The patient typically pays the remaining balance if there is any amount left over after the allowed amount has been paid. This amount should not to be confused with co-pay or deductibles owed by a patient.
Ancillary Service	Any service administered in a hospital or other healthcare facility other than room and board, including, imaging test, biometrics tests, physical therapy, and physician consultations.
Appeal	A medical provider submits an appeal in order to convince an insurance company to pay for services provided after the insurance carrier has decided not to cover costs a claim (denial or rejection was issued).
Authorization	A patient's health insurance plan requires the provider to get permission from their insurance payor before receiving certain healthcare services. A patient may be denied coverage if they see a provider for a service that needed authorization without first consulting the insurance company.
Centers for Medicare & Medicare Services (CMS)	CMS is the federal entity that manages and administers healthcare coverage through Medicare and Medicaid. CMS coordinates with providers and enrollees to provide healthcare to over 100 million Americans.
Claim (Insurance Claim, Medical Insurance Claim)	A standard form/format used to report billable services to an insurance company. A medical insurance claim is a formal request to an insurance company asking for a payment based on the terms of the insurance policy. The insurance company reviews the claim for its validity and then pays out to the insured or requesting party (on behalf of the insured) once approved. Multiple claim forms are used in the healthcare industry, depending on the type of service rendered (ambulance, nursing home, hospital, physician office, etc.) The two most common forms are: • CMS 1500 (formerly HCFA) – used for billing of professional charges

	• CMS 1450 (also called UB04) – used for hospital/facility charges
Claim Hold	The process of holding a billing claim for a period of time for internal review. Typically, this is done to conduct a quality assurance check prior to submitting to the insurance company.
Coinsurance	An amount, typically a percentage, contractually agreed-upon between the insurance company and the guarantor that will be paid by the insurance company after the guarantor has met other payment obligations. Example: $ 15,000 charge minus $ 10,000 deductible (paid by guarantor) equals $ 5,000 balance minus 20% coinsurance ($1,000 due from guarantor) equals $ 4,000 billable to insurance company
Contractual adjustment	The mutually agreed upon difference between the charge amount on a claim and the allowed amount applied by the insurance company. A binding agreement between a provider, patient, and insurance company wherein the provider agrees to portions of charges that it will adjust ("write off") on behalf of the patient. Contractual adjustments may occur when there is a discrepancy between what a provider charges for healthcare services and what an insurance company has decided to pay for that service.
Coordination of Benefits (COB)	COB occurs when a patient is covered by more than one insurance plan. In this situation, one insurance company will become the primary carrier, all other companies will be considered secondary, and tertiary carriers that may cover costs left after the primary carrier has paid.
Copayment (co-pay)	A patient's co-pay is the amount that must be paid to a provider (hospital or physician) before they receive any treatment or services. Co-pays are separate from a deductible, and will vary depending on a patient's insurance plan. Example: $ 300 charge minus $ 50 co-payment equals $ 250 billable to insurance company
Current Procedural Terminology (CPT) Codes	CPT Codes represent treatments and procedures performed by a physician in a 5-digit format. Physicians and their coding teams determine the appropriate CPT, HCPCS, ICD-10, and other codes that explain the services and diagnoses provided in each patient encounter. The CPT, HCPCS, ICD-10, and other codes and modifiers are reported on insurance claims to justify reimbursement for those services.

	CPT is the classification system jointly developed by the American Medical Association (AMA) and CMS.
Deductible	The amount a guarantor must pay before an insurance carrier starts their healthcare coverage. Deductibles range in price according to terms set in a person's health plan. Example: $ 15,000 charge minus $ 10,000 deductible (paid by guarantor) equals $ 5,000 billable to insurance company
Department of Health and Human Services (HHS)	The mission of the U.S. Department of Health & Human Services (HHS) to enhance and protect the health and well-being of all Americans. The department fulfills that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services. The HHS has 11 operating divisions, including the Centers for Medicare & Medicaid Services (CMS), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH).
Dependent	The individuals eligible for coverage under a particular guarantor. Example: In the case of a single mother with coverage, the mother would be the guarantor, and the children would be dependents.
Group Name	The name of the group, insurance carrier, or insurance plan that covers a patient.
Group Number	A number given to a patient by their insurance carrier that identifies the group or plan under which they are covered.
Guarantor	The party paying for an insurance plan who is not the patient. Parents, for example, would be the guarantors for their children's health insurance.
Healthcare Common Procedure Coding System (HCPCS) Codes	HCPCS codes represent produces, supplies, and services used in the course of patient treatment. Physicians and their coding teams determine the appropriate CPT, HCPCS, ICD-10, and other codes that explain the services and diagnoses provided in each patient encounter. The CPT, HCPCS, ICD-10, and other codes and modifiers are reported on insurance claims to justify reimbursement for those services. HCPCS is a classification system jointly developed by the American Medical Association (AMA) and CMS. It is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes, such

	as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.
Health Maintenance Organization (HMO)	An HMO is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally will not cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage.
Inpatient	Healthcare treatment that requires an overnight hospital stay. Billing processes and reimbursements differ significantly between inpatient and outpatient settings.
International Classification of Disease (ICD)-10 Codes	ICD codes represent diagnoses made by physicians regarding a patient's health. Physicians and their coding teams determine the appropriate CPT, HCPCS, ICD-10, and other codes that explain the services and diagnoses provided in each patient encounter. The CPT, HCPCS, ICD-10, and other codes and modifiers are reported on insurance claims to justify reimbursement for those services. 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). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. ICD-10 codes are the updated international set of codes based on the preceding ICD-9 codes.
Local Coverage Determination (LCD)	An LCD is a decision by a Medicare Administrative Contractor (MAC) whether to cover a particular service on a MAC-wide basis.
Managed Care Plan	A health insurance plan whereby patients can only receive coverage if they see providers who operate in the insurance company's network.
Maximum Out of Pocket	The maximum amount a patient is required to pay. After a patient reaches their maximum out-of-pocket, their healthcare costs should be covered by their plan.
Medicare Administrative Contractor (MAC) **(Previously known as Fiscal Intermediary)**	A MAC (previously known as Fiscal Intermediary) is contracted with CMS to serve as a clearinghouse to process Medicare claims, as CMS itself does not process claims. Different MACs operate in different parts of the country, and each may manage different claim type combinations. Providers, facilities, and other billing entities in the states within each MAC's jurisdiction submit their claims to that MAC for reimbursement. Each MAC must follow standard CMS rules for reimbursement and claims processing (NCD), and each can make local decisions (LCD) when CMS rules are not clear. The Medicare

	Administrative contractor for Northern and Southern California is Noridian, LLC.
Medicaid (Medical Assistance, Medi-Cal)	Medicaid is a joint federal and state assistance program started in 1965 to provide health insurance to lower-income persons. Both state and federal governments fund Medicaid programs, and each state is responsible for managing its own version of Medicaid within the minimum requirements established by federal law. Significant program differences exist from state to state. The state of California refers to its program as Medi-Cal.
Medical Necessity	This term refers to healthcare services or treatments that a patient requires to treat a serious medical condition or illness. This does not include cosmetic or investigative services.
Medical Record Number (MRN)	A unique number attributed to a person's medical record so it can be differentiated from other medical records.
Medicare	Medicare is a health insurance program under the Social Security Administration's Health Care Financing Administration that consists of 2 parts: Medicare Part A and Medicare Part B. **Medicare Part A –** Hospital Insurance**.** This is a hospital insurance (including skilled nursing facility and home health care) for almost everyone over the age of 65, the permanently disabled, and those with chronic renal failure. Coverage under Part A Medicare is automatic. **Medicare Part B –** Medical Insurance. Part B covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health care, and some home health and ambulance services. The patient pays a monthly premium for this coverage. **Medicare Part C –** Medicare Advantage. Medicare-approved plans that allow private health insurance companies to offer Medicare benefits to Part A and Part B enrollees. Medicare Advantage plans are typically offered in HMO and PPO models and provide additional benefits. Coverage rules and reimbursements vary by plan. **Medicare Part D** - Outpatient Prescription Drug Insurance. Part D is provided only through private insurance companies that have contracts with the government—it is never provided directly by the government (like Original Medicare).

Medi-Medi	Some people qualify for both Medicare and Medicaid and are called "dual eligibles." This is also referred to as "Medi-Medi." For services that both Medicare and Medi-Cal cover (such as doctor's visits, lab tests, and hospital care) Medicare pays first, and Medi-Cal pays second. Medi-Cal will pick up some costs not covered by Medicare, such as co-payments and coinsurance amounts. Medi-Cal pays for your Medicare co-payments and deductibles.
Medicare Secondary Payer	The insurance company that covers any remaining expenses after Medicare has paid for a patient's coverage.
Modifier	Modifiers are additions to CPT codes that explain alterations and modifications to an otherwise routine treatment, exam, or service.
National Coverage Determination (NCD)	An NCD is a United States' nationwide determination of whether Medicare will pay for an item or service.
Network Provider	A medical provider within a health insurance company's network that has contracted with the company to provide discounted services to a patient covered under the company's plan.
National Provider Identifier (NPI) Number	A unique 10-digit number ascribed to every healthcare provider in the U.S. as mandated by HIPAA. The NPI number is required on every insurance claim.
Office of Inspector General (OIG)	The organization responsible for establishing guidelines and investigating fraud and misinformation within the healthcare industry. The OIG is part of the Department of Health and Human Services.
Out-of-Network	Out-of-network refers to providers outside of an established network of providers who contract with an insurance company to offer patients healthcare at a discounted rate. People who go to out-of-network providers typically have to pay more money to receive care.
Outpatient	Healthcare treatment that does not require an overnight hospital stay, including a routine visit to a primary care doctor or a non-invasive surgery. Billing processes and reimbursements differ significantly between inpatient and outpatient settings.
Patient Responsibility	This refers to the amount a patient owes a provider after an insurance company pays for their portion of the medical expenses.

Patient Statement	A printed bill that displays the details such as the amount that each patient has to pay, service dates, charges, and transaction descriptions along with the patient's demographic details is called as patient statement.
Primary Care Physician (PCP)	The physician who provides the basic healthcare services for a patient and recommends additional care for more serious treatments as necessary.
Point of Service Plans	A plan whereby patients with HMO membership may receive care at non-HMO providers in exchange for a referral and paying a higher deductible.
Pre-authorization/ Pre-certification	Some insurance plans require that a patient receive pre-authorization or pre-certification from the insurance company prior to receiving certain medical services to make sure the company will cover expenses associated with those services. The insurance company issues a particular alpha-numeric code when approved, which must be included on the claim form.
Preferred Provider Organization (PPO)	A PPO is a managed care organization of providers who contract with an insurance company to provide services to enrolled patients. It is generally more flexible than an HMO.
Referral	A provider recommends a different provider to a patient to receive specialized treatment. Depending on the terms of their insurance coverage, patients may be required to obtain a referral prior to seeing a specialist or other physician, and the refusal to obtain a referral may result in the subsequent specialist service being ineligible for insurance coverage.
Remittance Advice (R/A)	The R/A is also known as the Explanation of Benefits (EOB), which is the document attached to a processed claim that explains the information regarding coverage and payments on a claim.
Responsible Party/ Guarantor	The person who pays for a patient's medical expenses, also known as the guarantor. The guarantor may be the patient, or the person responsible for dependent coverage. Example: In the case of a single mother with coverage, the mother would be the guarantor, and the children would be dependents.
Self-Pay	Payment made by the patient for healthcare at the time they receive it at a provider's facilities.
Subscriber	The individual covered under a group policy. For instance, an employee of a company with a group health policy would be one of many subscribers on that policy.
Supplemental Insurance	Supplemental insurance can be a secondary policy or another insurance company that covers a patient's healthcare costs after receiving coverage

	from their primary insurance. Supplemental insurance policies typically help patients cover expensive deductibles and co-pays.
Treatment Authorization Request (TAR)	A unique number the insurance company assigns the provider for billing purposes. A provider must receive the insurance company's TAR number before administering healthcare to a patient covered by the company.
Tax Identification Number (TIN)	A unique number a patient or a company may have to produce for billing purposes in order to receive healthcare from a provider. The TIN is also known as the employment identification number (EIN).
TRICARE	TRICARE is the federal health insurance plan for active service members, retired service members, and their families, in addition to survivors of service members. TRICARE was previously known as CHAMPUS.

Terminology and Definitions specific to Clinical Research Operations & Billing

Anti-kickback Statute	A criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business.
Billing Designation	Identification within the coverage analysis billing grid of how an individual patient care cost is covered within a clinical research study, and the party responsible for covering the cost of the item. Billing designations may routine cost (RC), standard of care (SOC), Sponsor paid (S), or non-billable (NB).
Billable Event	Patient care items/services such as clinic visits, procedures, radiology, labs, etc. that may generate a charge in the healthcare billing system. These events are typically associated with a CPT and/or HCPCS code.
Clinical Trial Agreement (CTA)	A Clinical Trial Agreement (CTA) is a legally binding agreement that manages the relationship between the sponsor that may be providing the study drug or device, the financial support and /or proprietary information and the institution that may be providing data and/or results, publication, input into further intellectual property.
Condition Code 30	Identifies non-research services (or routine costs) provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial, and is included on institutional claims.
Contract Research Organization (CRO)	A contract research organization (CRO) is an organization that provides support to the pharmaceutical, biotechnology, and medical device industries in the form of

	research services outsourced on a contract basis. A CRO's services may include biopharmaceutical development, biologic assay development, commercialization, pre-clinical research, clinical research, clinical trials management, and pharmacovigilance. CROs provide a more affordable outlet for companies to pursue new medicines, and a cost-effective solution to develop drugs for even niche markets.
Coverage Analysis (aka Medicare Coverage Analysis)	This is a process that: a) determines if the clinical study is a Qualifying Clinical Trial, and b) ensures costs for clinical study items/services/procedures are designated as research costs or routine costs, to ensure proper billing of such costs to either the clinical study, Sponsor or a third party payor.
Coverage with Evidence Development (CED)	A CMS program that provides conditional coverage for new technology and procedures while it collects information from providers regarding effectiveness. It requires participants to enroll in a clinical trial or registry, and the corresponding National Clinical Trial (NCT) # must be included on the claim with the appropriate designated CPT and ICD codes.
Diagnosis code Z00.6 (formerly known as V70.7)	Identifies an encounter for examination for normal comparison and control in clinical research program. For institutional claims, ICD-10 diagnosis code Z00.6 and condition code 30 are used to denote services provided on a clinical study. For professional claims, the ICD-10 diagnosis code Z00.6 (together with additional special billing rules) is used to identify items/services on a clinical study.
Expanded Access protocol (aka Compassionate Care)	Expanded access, also known as "compassionate use," is the use outside of a clinical trial, of an investigational medical product (i.e., one that has not been approved by FDA), for treatment of a patient when patient's enrollment in a clinical trial is not possible (e.g., a patient is not eligible for any ongoing clinical trials, or there are no ongoing clinical trials). In this case, the patient may be able to receive the product, when appropriate through expanded access.
Double Billing (Double Dipping)	Double billing occurs when the same item/service is paid for by two different sources (e.g. patient's insurance and study sponsor).
False Claims Act (FCA)	Federal law that imposes liability on persons and companies who defraud governmental programs. It is the federal Government's primary litigation tool in combating fraud against the Government. This legislation prohibits anyone from knowingly submitting or causing to be submitted a false or fraudulent claim.
Indication	Description of use of an FDA approved drug or device in the treatment, prevention or diagnosis of a recognized disease or condition.

Investigational New Drug (IND) Application	An Investigational New Drug Application (IND) is a request for authorization from the FDA to administer an investigational drug or biological product to humans. Such authorization must be obtained prior to interstate shipment and administration of any new drug or biological product that is not the subject of an approved New Drug Application or Biologics/Product License Application.
Investigational Device Exemption (IDE)	An investigational device exemption (IDE) allows the investigational device to be used in a clinical study in order to collect safety and effectiveness data. Clinical studies are most often conducted to support a Pre-market Approval application. Investigational use also includes clinical evaluation of certain modifications or new intended uses of legally marketed devices. All clinical evaluations of investigational devices, unless exempt, must have an approved IDE before the clinical study is initiated.
Medically Necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meets accepted standards of medicine.
Medicare Benefit Category	Medicare coverage is limited to items/services that are considered "reasonable and necessary" for the diagnosis or treatment of an illness or injury, and within the scope of a Medicare benefit category (i.e. the item/services is not excluded from Medicare coverage).
National Clinical Trial (NCT) Number	An 8-digit number, assigned by the ClinicalTrials.gov website, to each clinical trial and registry. All research-related charges on a claim must include the pertinent study NCT#, and clinical trials must be publicly registered on the website prior to professional publication.
Non-Billable Event	An item/service that is provided at no cost and/or does not generate a charge in healthcare billing system. Examples include labs sent to central lab for processing, or an investigational product that is provided free.
Off Label use of drug or device	An “off-label” use is one the FDA has not expressly approved, i.e. change in dosing, patient population, purpose. The Food Drug and Cosmetic Act (“FDCA”) prohibits manufacturer from marketing or promoting drug or device for off-label use. 21 U.S.C. § 331(a), (d)
Office of Inspector General (OIG)	The organization responsible for establishing guidelines and investigating fraud and misinformation within the healthcare industry. The OIG is part of the Department of Health and Human Services.

Open Payments – Centers for Medicare & Medicaid Services (aka Sunshine Act)	Open Payments is a federal program, required by the Affordable Care Act, that collects information about the payments drug and device companies make to physicians and teaching hospitals for things like travel, **research**, gifts, speaking fees, and meals. It also includes ownership interests that physicians or their immediate family members have in these companies.
QO modifier	Identifies an investigational clinical item/service provided in a clinical research study that is in an approved clinical research study. An investigational clinical item/service is defined as an item/service that is being investigated as an objective within the clinical research study (this item/service that may be approved, unapproved, or otherwise covered, or not covered under Medicare).
Q1 modifier	Routine clinical service provided in a clinical research study that is in an approved clinical research study. A routine clinical services are defined as those items and services that are covered for Medicare beneficiaries outside of the clinical research study; are used for the direct patient management within the study; and, do not meet the definition of investigational clinical services. Routine clinical services may include items or services required solely for the provision of the investigational clinical services (e.g., administration of a chemotherapeutic agent); clinically appropriate monitoring, whether or not required by the investigational clinical service (e.g., blood tests to measure tumor markers); and items or services required for the prevention, diagnosis, or treatment of research related adverse events (e.g., blood levels of various parameters to measure kidney function).
Qualifying Clinical Trial (QCT)	A study that meets Medicare's criteria under the National Coverage Determination (NCD 310.1) "Routine Costs in Clinical Trials".
Research "only"	Items and/or services that are not an allowable expense to the patient, not considered routine, or covered and paid by the study sponsor.
Routine costs	The following items and/or services will be covered as a "routine cost" of the study so long as it is not agreed to be paid or paid by the sponsor and it is not promised free to the subject in the informed consent: 1. Items and services that are otherwise generally available (e.g., conventional care) to Medicare beneficiaries (i.e., there exists a benefit category, it is not statutorily excluded, and there is not a national non-coverage decision, etc.); 2. Items or services required solely for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

	3. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service in particular, for the diagnosis or treatment of complications 4. All other Medicare rules apply
Study Sponsor	An individual, institution, company or organization (for example, a contract research organization) that takes the responsibility to initiate, manage or finance the clinical trial, but does not actually conduct the investigation.

The Revenue Cycle Management Process

Introduction

The term "Revenue Cycle" implies that billing is a cyclical process. In reality, the healthcare billing process is linear, much like billing in other industries.

Specifically, there are 4 major components to the Revenue Cycle process.
The customer/client/patient:

1) Identifies a need for service and contacts a service provider to arrange for service delivery
2) Receives the service, and perhaps makes a deposit or installment payment
3) Receives a billing statement
4) Pays the bill, with no outstanding balance or billing issues

The healthcare revenue cycle process is more complex than for other industries due to the multiple parties involved in reimbursement. Different governmental agencies, insurance companies, research sponsors, and others may be contractually responsible for the payment of medical services, and each potential payor must follow established regulations and/or self-imposed additional billing rules.

There are several potential leakage/failure points in the revenue cycle that include, but are not limited to:

- No referral
- Registration, coding or billing errors
- Unverified insurance coverage
- Underpaid claims
- Denied appeals

Revenue Cycle Components

1) The customer/client/patient identifies a need for service and contacts a service provider to arrange for service delivery

When a patient calls for appointment, an appropriate and sufficient time slot must be scheduled and designated. If it is the patient's first visit, information must be collected by the front office to prepare for the patient visit. This includes basic information about the patient, including name, address, date of birth, and reason for visit. The front office must also collect insurance information from the patient, including the name of the insurance provider, and the patient's policy number. Setting up and updating medical files for the patient expedites the billing process and makes patient check-in easier and more efficient.

2) The customer/client/patient receives the service, and perhaps makes a deposit or installment payment

Scheduling:

A patient may arrive in a physician office, hospital department, ambulatory surgery center, emergency room, or other setting. Each location involves different billing rules due to regulatory requirements. Each service received also involves different billing rules due to regulatory requirements. Every room used, provider visited, and resource used must be identified, documented, and coded for inclusion on an insurance claim, patient statement, or sponsor invoice.

Coding and billing:

Before a claim can be officially directed to an insurance payor, it must first satisfy certain official requirements. These requirements differ between coding and billing procedures, as well as insurance providers and types of medical services provided. For example, the billing process must be compliant with requirements set by the Health Insurance Portability and Accountability Act (HIPAA), and the Office of Inspector General (OIG).

In general, compliance in medical billing means, ensuring that fees are charged accurately. The medical billing department must confirm that each charge is related to a specific procedure code. Different medical facilities have different charges and fees for their services, so charges must match the standard set by the medical facility or medical practice (standard fee schedule).

The medical billing department must also confirm that every code is billable. Whether or not a code is billable depends on the payer, generally the insurance provider. In the case of insurance providers, each payer has a set of rules that determine what they can and cannot be billed for under their policyholder's insurance plan. If a claim is sent out to a payer that includes charges outside of these rules, the claim may be denied and returned to the provider (hospital or physician) to be corrected. Denied claims are time consuming, resource wasting, and complicate the revenue cycle process for all parties involved.

Insurance Claims Process:

After patient receives services from a licensed provider (hospital or physician), these services are recorded (posted) and assigned appropriate codes by the medical coder. ICD codes are used for diagnoses, while CPT codes are used for various treatments and procedures. The summary of services, communicated through these code sets, make up the claim and/or patient statement. Patient demographic data and insurance information are added to the claim and/or patient statement, and they are ready to be transmitted to the insurance company and/or patient.

Claims adjudication and denials management:

When the insurance payer receives an insurance claim from a healthcare provider, the claim is reviewed through a process called adjudication. During adjudication, the insurance provider puts the claim through a number of different steps, considering various factors, in order to evaluate the bill. The insurance payer determines whether they will pay the entire claim, a portion of the claim, or if they will deny the claim. The amount of payment the insurance payer issues to the provider is based on the policy held by the patient and its contract with the medical provider (hospital or physician).

After the claim goes through adjudication, the decision to pay all, some, or none of the claim is sent back to the healthcare provider in the form of a report (remittance advice). If the insurance provider decided not to cover the entire claim, the medical billing department needs to determine whether more than one insurance provider covers the patient. If the patient is covered by additional insurance plans, the medical billing department sends a claim for the remaining amount to this second payer. Claims must be filed in a particular sequence, and it is crucial that the provider receives the maximum appropriate reimbursement as agreed upon between the provider and the payer.

If any services are denied by the insurance provider, the medical provider may need to submit medical records (if required) and appeal the denial requesting that payment for services be issued in accordance with the medical records or other documentation submitted to support the initial claim.

3) The customer/client/patient receives a billing statement; 4) Pays the bill, with no outstanding balance or billing issues

Account Receivables and Patient Billing:

After the healthcare provider has received appropriate reimbursements for medical services, payments received are then applied to the patient's account. If the insurance provider did not cover some (or any) service rendered, leaving portions of the claim unpaid, these leftover charges are passed on to the patient. The medical billing department must confirm that the amount reimbursed by the insurance provider, in addition to the total billed to the patient, equals the expected reimbursement for all of the medical services rendered.

When billing the patient directly, it is important that the patient statement (bill) contain any and all information pertaining to entire transaction. The medical billing department must confirm that the patient statement contains a list of services provided by the medical provider, as well as the dates these services were rendered. The statement will also contain information regarding the payments already made by the insurance provider deducted from the overall total amount billed, and the leftover balance the patient will be responsible for paying. Making sure this information is accurate and clear is important in order to ensure the patient understands his/her financial responsibility.

Medical Billing Claims Types

CMS 1500 Form (Professional Billing) - The CMS 1500 is a paper medical claim form used for transmitting claims based on coverage by Medicare and Medicaid plans. Commercial insurance providers often require that providers use CMS 1500 forms to process their own paper claims.

UB-04 (CMS 1450) Form (Hospital billing) - A form used by providers for filing claims with insurance companies. The UB04 form has a format similar to that of the CMS 1500 form.