PATIENT FRIENDLY BILLING®
PATIENT GLOSSARY OF BILLING TERMS

To the Provider:

The ***PATIENT FRIENDLY BILLING®*** Project is a nationwide initiative to make financial communications to patients clear, concise, and correct. The Healthcare Financial Management Association (HFMA) leads the initiative, in partnership with the American Hospital Association (AHA), the Medical Group Management Association (MGMA), and other leading provider and consulting organizations.

The ***PATIENT FRIENDLY BILLING®*** project designed this glossary to be used as a guide to commonly used terms for financial communication with patients and consumers. The terms were gathered from several sources, including hospital bills and statements. The terms then were defined using common language that most patients would understand. Special care was taken to exclude jargon that the industry may use but that patients rarely understand. These terms were then reviewed and revised to increase readability by many industry professionals and reading specialist and consultant Mark Hochhauser, Ph.D.

The guide can be printed as a multi-page document or be placed online as a web page. Individual terms can be placed on the back of a bill or statement, as hypertext on a web page, or as a document to distribute. These terms are an excellent source of information for creating call scripts and training customer support staff or anyone who has contact with patients about financial matters.

Members of the project hope that all providers and insurance companies start to use these terms and definitions when communicating with patients. Further initiatives are underway to include terms used on Explanation of Benefits and insurance cards used by insurance company organizations.

The ***PATIENT FRIENDLY BILLING®*** project invites comments to this version of the glossary. The glossary is planned for release in June of 2003, and will be updated yearly. If you have any suggestions, changes, additions, or clarifications, please send an email to Jeff Shutak, CHFP, jshutak@tmhf.org with the subject line "glossary."

Project sponsors also are seeking the endorsement of this glossary from industry associations and groups. If you or your organizations are interested in endorsing the glossary or lending your support to the ***PATIENT FRIENDLY BILLING®*** project, please contact Suzanne Lestina at slestina@hfma.org.

NOTE: An asterisk (*) after a term means that this definition, in whole or in part, is taken from the Medicare Glossary, http://www.medicare.gov, February 2003

PATIENT FRIENDLY BILLING®—Helping You Understand Your Healthcare Bills

How this glossary can help you.
The ***PATIENT FRIENDLY BILLING®*** project, working with other healthcare groups, has produced this booklet to help you understand many of the words on your healthcare bills and statements. By explaining the terms on your bill and statements, this booklet will also help you understand how to pay your bill and statements.

Do your healthcare bills confuse you?
Government and state laws require doctors, hospitals, ambulance services, therapists, and other caregivers to use different bill forms and sometimes-different terms for treatment. You may receive a lot of paper after a doctor or hospital visit, and may be confused by these bills and the words on them.

This booklet also includes a sample of a typical bill. Printed on the sample bill are notes explaining what different areas of the bill mean. We have also included some questions that patients often ask their doctors or hospitals about their bills, and answers to those questions. There is also a page that you can use to write notes or questions to ask your doctor or hospital about your bill. This glossary is not a legal document.

You Can Help
We hope this booklet helps you. If you'd like to help us improve this booklet, please send us your ideas by going to the Patient Friendly Billing site at http://www.patientfriendlybilling.org or writing us at Patient Friendly Billing, c/o HFMA, Two Westbrook Corporate Center, Ste. 700, Westchester, IL 60154.

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PATIENT GLOSSARY OF HEALTHCARE BILLING TERMS

A

Account- Your charges for a medical visit.
Account Number- Number you're given by your doctor or hospital for a medical visit.
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. *
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.*
All-inclusive Rate- Payment covering all services during your hospital stay.
Ambulatory Payment Classifications (APC)- A Medicare payment system that classifies outpatient services so Medicare can pay all hospitals the same amount.
Ambulatory Care- All types of health services that do not require an overnight hospital stay.*
Ambulatory Surgery- Outpatient surgery or surgery that does not require an overnight hospital stay.
Amount Charged- how much your doctor or hospital bills you.
Amount Paid-The dollar amount that you paid for your doctor or hospital visit.
Amount Not Covered- What your insurance company does not pay. It includes deductibles, co-insurances, and charges for non-covered services.
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.

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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.
Applied to Deductible- Portion of your bill, as defined by your insurance company, that you owe your doctor or hospital.
Assignment- An agreement you sign that allows your insurance to pay the doctor or hospital directly.
Assignment of Benefits- When insurance payments are sent directly to your doctor or hospital.
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.

B

Balance Bill- How much doctors and hospitals charge you after your health plan, insurance company, or Medicare have paid its approved amount.
Beneficiary- Person covered by health insurance.
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.
Bill/Invoice/Statement- Printed summary of your medical bill.

C

Cardiology Charges- Charges for heart procedures. Examples are heart catheterization and stress testing.
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.
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.*
CHAMPUS- Insurance linked to military service, also know as TriCare.
Charity Care- Free or reduced-fee care for patients who have financial hardship.
Claim- Your medical bill that is sent to an insurance company for processing.
Claim Number- A number given to a medical service.
Clean Claim- A claim that does not have to be investigated by insurance companies before they process it.
Clinic- An area in a hospital or separate building that treats regularly scheduled or walk-in patients for non-emergency care.

COBRA Insurance- Health insurance that you can buy when you lose your job. It is generally

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more expensive than insurance provided through your job but less expensive than insurance purchased on your own when you are unemployed.

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 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.

Consent (for treatment)- An agreement you sign that gives your permission to receive medical services or treatment from doctors or hospitals.

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-payment- A cost sharing part of your bill that is your responsibility to pay. Also known as co-pay.

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.

Covered Benefit- A health service or item that is included in your health plan, and that is paid for either partially or fully.*

Covered Days- Days that your insurance company pays for in full or in part.

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.

D

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.

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 you**r** 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.

Discharge Hour- Hour when you were discharged.

Discount- Dollar amount taken off your bill, usually because of a contract with your hospital or doctor and your insurance company.

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

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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.
Durable Medical Equipment (DME) - Medical equipment that can be used many times, or special equipment ordered by your doctor, usually for use at home.

E

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.
Eligible Payment Amount- Those medical services that an insurance company pays for.
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.
Estimated Insurance- Estimated cost paid by your insurance company.
Enrollee- A person who is covered by health insurance.
Estimated Amount Due- How much the doctor or hospital estimates you or your insurance company owes.
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.
External Cause of Injury Code- A code describing a place or item that may have caused injuries, poisoning, or health problems.

F

Federal Tax ID Number- A number assigned by the federal government to doctors and hospitals for tax purposes.
Financial Responsibility- How much of your bill you have to pay.
Fiscal Intermediary (FI) - A Medicare agent that processes Medicare claims.
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.*

G

Guarantor- Someone who has agreed to pay the bill.

H

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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.

Health Care Financing Administration (HCFA)- Former name of the government agency now called the Centers for Medicare & Medicaid Services.
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.
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.
HIPAA- Health Insurance Portability and Accountability Act. This federal act sets standards for protecting the privacy of your health information.
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.

I

Incremental Nursing Charge- Charges for nursing services added to basic room and board charges.
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.
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.

L

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

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days of inpatient services after you use the first 90 benefit days. You must pay a fixed amount for each day of service.
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.

M

Mailer/Summary of Account- A monthly summary of services **(and charges?)** mailed to the person who pays the bill.
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.
Medicaid- A state administered, federal and state funded insurance plan for low-income people who have limited or no insurance.
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.
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 Assignment- Doctors and hospitals who 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 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).
Medigap- Medicare Supplement Insurance that pays for some services not covered by Medicare A or B, including deductible and coinsurance amounts.
Co-pay- Agreed amount of the charges for medical services that patients or guarantors must pay.
MRI- A type of X-ray; magnetic resonance brain or body images, usually done in a hospital's x-ray department.

N

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Network- A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.*
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.
Nursery- Nursing care charges for newborn babies.

O

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.
Oncology- Charges for treating cancer and related diseases.
Operating Room- A hospital or clinic area where surgeries are done.
Other Room and Board- Any extra charges that cannot be included in routine room and board charges.
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.
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.

P

Paid to Provider- Amount the insurance company pays your medical provider.
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.
Patient Amount Due- The amount charged by your doctor or hospital that you have to pay.
Patient Type- A way to classify patients--outpatient, inpatient, etc.
Pay This Amount -How much of your bill you have to pay.
Per Diem- Charged or paid by the day.
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

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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.

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.

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.

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.

Prepayments- Money you pay before getting medical care; also referred to as preadmission deposits.

Prevailing Charge- A billing charge that is commonly made by doctors in a specific region or community. Your insurance company determines this charge.

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 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.

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.

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, and 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.

R

Radiology- X-rays used to identify and diagnose medical problems.

Reasonable and Customary (R & C)- Billing charges that insurers believe are appropriate for services throughout a region or community.

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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.
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.
Renal Dialysis- Removal of wastes from the blood. Normally the kidneys would remove these wastes if they were functioning properly.
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.
Revenue Code- A billing code used to name a specific room, service (X-ray, laboratory), or billing sum.
Room and Board Private- Routine charges for a room with one bed.
Room and Board Semiprivate- Routine charges for a room with two beds.

S

Same-Day Surgery- Outpatient surgery.
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.
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 Begin Date- The date your medical services or treatment began.
Service Code- A code describing medical services you received.
Service End Date- The date your medical services or treatment ended.
Skilled Nursing Facility- An inpatient facility in which patients who do not need acute care are given nursing care or other therapy.
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.
Statement Covers Period- The date your services or treatment begin and end.

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 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.

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T

Total Charges- Total cost of your medical services.
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.

U

UB-04- A form used by hospitals to file insurance claims for medical services.
Units of Service- Measures of medical services, such as the number of hospital days, miles, pints of blood, kidney dialysis treatments, etc.
Utilization Review (UR)- Hospital staff who work with doctors to determine whether you can get care at a lower cost or as an outpatient.

V

W

Y

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.

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