**Basic Terminologies of Billing and EDI**

**HIPPA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient’s consent or knowledge. The US Department of Health and Human Services (HHS) issued the HIPAA Privacy Rule to implement the requirements of HIPAA. The HIPAA Security Rule protects a subset of information covered by the Privacy Rule.

The Privacy Rule standards address the use and disclosure of individuals’ health information (known as protected health information or PHI) by entities subject to the Privacy Rule. These individuals and organizations are called “covered entities.”

**Covered Entities:**

* Healthcare Providers
* Health Plans
* Healthcare Cleaning Houses
* Business Associates

**Consequences of PHI Breach:**

**First Tier:** Penalties can range from $100-$50,000 per incident (up to $1.5M). First tier penalties are given when a covered entity did not or could not have known about a breach.

**Second Tier:** These penalties can range from $1,000-$50,000 (up to $1.5M) per incident. In this tier, through proper diligence, the covered entity either knew or should have known about the breach — yet it is still not considered willful neglect.

**Third Tier:** Ranging from $10,000-$50,000 (up to $1.5M) per incident, these penalties are given when a covered entity acted with willful neglect but corrected the breach within 30 days.

**Fourth Tier:** These penalties are at least $50,000 per incident (up to $1.5M) and are for willful neglect without any proper corrections made in a timely fashion.

**Health Care Plan Types**

**Health Maintenance Organizations (HMOs):**

An HMO delivers all health services through a network of healthcare providers and facilities. With an HMO, you may have:

* The least freedom to choose your health care providers
* The least amount of paperwork compared to other plans
* A primary care doctor to manage your care and refer you to specialists when you need one so the care is covered by the health plan; most HMOs will require a referral before you can see a specialist.

**What doctors you can see:** Any in your HMO's network. If you see a doctor who is not in the network, you'll may have to pay the full bill yourself. Emergency services at an out-of-network hospital must be covered at in-network rates, but non-participating doctors who treat you in the hospital can bill you.

**What you pay:**

* **Premium:** This is the cost you pay each month for insurance.
* **Deductible:** Your plan may require you to pay the amount before it covers care except for preventive care.
* **Copays and/or co-insurance for each type of care:** A copay is a flat fee, such as $15, that you pay when you get care. Coinsurance is when you pay a percent of the charges for care, for example 20%. These charges vary according to your plan and they are counted toward your deductible.

**Paperwork involved:** There are no claim forms to fill out.

**Preferred Provider Organization (PPO):**

With a PPO, you may have:

* A moderate amount of freedom to choose your health care providers -- more than an HMO; you do not have to get a referral from a primary care doctor to see a specialist.
* Higher out-of-pocket costs if you see out-of-network doctors vs. in-network providers
* More paperwork than with other plans if you see out-of-network providers

**What doctors you can see:** Any in the PPO's network; you can see out-of-network doctors, but you'll pay more.

**What you pay:**

* **Premium:** This is the cost you pay each month for insurance.
* **Deductible:** Some PPOs may have a deductible. You will likely have to pay a higher deductible if you see an out-of-network doctor.
* **Copay or coinsurance:** A copay is a flat fee, such as $15, that you pay when you get care. Coinsurance is when you pay a percent of the charges for care, for example 20%.
* **Other costs:** If your out-of-network doctor charges more than others in the area do, you may have to pay the balance after your insurance pays its share.

**Paperwork involved:** There's little to no paperwork with a PPO if you see an in-network doctor. If you use an out-of-network provider, you'll have to pay the provider. Then you have to file a claim to get the PPO plan to pay you back.

**Exclusive Provider Organization (EPO):**

With an EPO, you may have:

* A moderate amount of freedom to choose your health care providers -- more than an HMO; you do not have to get a referral from a primary care doctor to see a specialist.
* No coverage for out-of-network providers; if you see a provider that is not in your plan’s network – other than in an emergency – you will have to pay the full cost yourself.
* Lower premium than a PPO offered by the same insurer

**What doctors you can see:** Any in the EPO's network; there is no coverage for out-of-network providers.

**What you pay:**

* **Premium:** This is the cost you pay each month for insurance.
* **Deductible:** Some EPOs may have a deductible.
* **Copay or coinsurance:** A copay is a flat fee, such as $15, that you pay when you get care. Coinsurance is when you pay a percentage of the charges for care, for example 20%.
* **Other costs:** If you see an out-of-network provider you will have to pay the full bill.

**Paperwork involved:** There's little to no paperwork with an EPO.

**Point of Service Plan (POS):**

A POS plan blends features of an HMO with a PPO. With POS plan, you may have:

* More freedom to choose your health care providers than you would in an HMO
* A moderate amount of paperwork if you see out-of-network providers
* A primary care doctor who coordinates your care and who refers you to specialists

**What doctors you can see:** You can see in-network providers your primary care doctor refers you to. You can see out-of-network doctors, but you'll pay more.

**What you pay:**

* **Premium:** This is the cost you pay each month for insurance.
* **Deductible:** Your plan may require you to pay the amount of a deductible before it covers care beyond preventive services. You may pay a higher deductible if you see an out-of-network provider.
* **Copays or coinsurance:** You will pay either a copay, such as $15, when you get care or coinsurance, which is a percent of the charges for care. Copayments and coinsurance are higher when you use an out-of-network doctor.

**Paperwork involved:** If you go out-of-network, you have to pay your medical bill. Then you submit a claim to your POS plan to pay you back.

**Difference**

* With an HMO, or health maintenance organization plan, you pick one PCP under your plan’s network who provide routine care and refers you to in network specialists for additional care. HMOs will not cover out of network care.
* With a POS, or point-of-service plan, you also have one Primary care physician (PCP) who manages your access to other doctors. However, you can visit doctors out of network but it will cost more.
* With a PPO, or preferred provider organization plan, you don’t need a referral to seek additional care. You have more freedom to choose which doctors to see. But out of network will cost more.

|  |  |  |  |
| --- | --- | --- | --- |
| Plan Type | Network Coverage & Restrictions | Referrals | Out-of-Pocket Costs |
| HMO | Must stay in-network, except for emergencies | Typically required | Low |
| PPO | Flexible, but staying in-network will likely cost less | May not be required | High |
| EPO | Must stay in-network, except for emergencies | May not be required | Higher than HMO, lower than PPO |
| POS | Flexible, but staying in-network will likely cost less | Required | Higher than HMO and EPO, lower than PPO |

**HMO stands for “Health Maintenance Organization.”** HMO plans contract with doctors and hospitals creating a network to provide health services for members in a specific area at lower rates, while also meeting quality standards. HMO plans require you to select a primary care physician (PCP) and usually require a referral from your PCP to see a specialist or to have certain tests done. If you choose to see a provider outside of the HMO’s network, the plan will not cover those services and you will be responsible for all charges.

An **EPO means “Exclusive Provider Organization.”** This plan provides members with the opportunity to choose in-network providers within a broader network and to visit specialists without a referral from their primary care doctor. EPO plans offer a larger network than an HMO plan and typically do not have the out-of-network benefits of PPO plans. Generally, EPO plans cost more than an HMO, but less than a PPO.

**PPO stands for “Preferred Provider Organization.”** PPO plans are often more flexible when it comes to choosing a doctor or a hospital. These plans still include a network of providers, but there are fewer restrictions on the providers you choose. PPO plans do not require you to select a primary care physician (PCP), giving you a broader network of providers.

An example of comparing prices between HMO, PPO, and EPO is as follows:

For a family of four with a yearly income of $75,000, the estimated monthly premium costs for each plan might be:

* HMO: $400
* PPO: $600
* EPO: $550

In this example, the HMO plan offers the lowest monthly premium cost, but may have restrictions on accessing care and higher out-of-pocket costs for services not covered by the plan. The PPO plan offers more flexibility and a broader network of providers, but at a higher monthly premium cost. The EPO plan offers a balance between cost and network access, but with higher out-of-pocket costs for medical services.

**Q. Which plan should you choose?**

Each plan type has different benefits, so it depends on your health needs when choosing the right plan type. If you are looking for flexibility when choosing providers and locations, a PPO plan may better fit your needs. An EPO plan may be a better option if you travel often and want the flexibility of a larger network, but don’t necessarily need out-of-network benefits. If you regularly seek care in a certain geographic area and are looking for a health insurance plan at a lower price point, consider an HMO plan.

It is important to compare the different types of health insurance plans based on the individual's or family's specific healthcare needs and budget, in order to make the best choice.

**Copay**

A health insurance copayment is a fixed amount set by an insurance plan for sharing the cost of covered services between the plan and the customer. The cost-sharing system is a critical selling point for each plan because it breaks down how much you’ll actually owe for services, prescriptions, doctor visits, and more.

It’s important to understand the cost-sharing details of any health insurance plan you’re considering, especially for frequently used services or prescriptions. Keep in mind that these are out-of-pocket costs you’ll pay in addition to monthly premiums and costs for non-covered services.

Cost sharing primarily comes in three forms:

* **Copayment:** This is a fixed, flat fee for certain kinds of office visits, prescription drugs, or other services. Because the health insurance copay is fixed, you’ll know ahead of time exactly how much you owe. If your policy lists a copayment of $25 for a doctor visit, you pay that amount each time you see the doctor.
* **Coinsurance:** This is a percentage of the total cost for a covered medical service, instead of a fixed copayment. If the insurance company owes a doctor $100 for your visit, and you have a coinsurance of 25 percent, you’ll pay $25 for the visit. You may pay it at the time of service or get a bill for your portion after the visit.
* **Annual deductible:** An annual deductible is a set amount that you may be required to pay toward covered medical care within a single year. For example, if you have a $3,000 annual deductible, you may need to pay that amount out of pocket toward covered medical care before the insurance company will begin paying your claims.

Generally, you’ll pay completely out of pocket for covered medical services until you reach your plan’s yearly deductible. After that, your insurance starts to pay for its share of costs, and you may owe a copayment or coinsurance for certain services as your “share.”

**Billing Provider**

Billing provider is an individual, agent, business, corporation, or other entity who, in connection with submission of claims to the Department, receives or directs payment from the Department on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider. Simply it’s an individual or entity enrolled in Medicaid that bills the department for services provided to a member.

**Rendering Provider**

A Rendering/Servicing provider is one who provides services through a Group, Facility, Agency, Organization or an Individual/Sole Proprietor.  A Rendering/Servicing provider does not bill directly to Michigan Medicaid. The Billing Provider that is associated to this applicant type, submits claims and receives payments for the Rendering/Servicing provider. This Billing Provider must be approved in CHAMPS (Community health automated Medicaid Processing System) prior to the submission of a new enrollment application for a Rendering/Servicing provider.

**Difference between Billing Provider and Rendering Provider**

In the context of medical billing, the "billing provider" and "rendering provider" refer to two different roles in the process of seeking reimbursement for medical services.  
  
The "billing provider" is the individual or organization responsible for submitting a claim to a payer (e.g. Medicare, Medicaid, private insurance) for payment for services rendered to a patient. The billing provider is typically the entity that has a direct financial relationship with the payer.  
  
The "rendering provider" is the individual or organization that actually provides the medical service to the patient. This could be a doctor, nurse, or other medical professional. The rendering provider may be different from the billing provider, as the medical service may be provided by one entity, but the billing and financial responsibilities may be handled by another entity.  
  
For example, a physician may work for a hospital, but bill for their services under their own name. In this case, the physician would be the rendering provider and the billing provider. The hospital would only be involved as the place where the service was rendered, but would not be responsible for billing the insurance company.

**Note:**

*The billing provider and rendering provider can be the same person. In healthcare, the billing provider is the individual or organization responsible for submitting a claim to insurance for reimbursement, while the rendering provider is the person who actually provides the service. If a single individual provides the service and submits the claim, they can be both the billing and rendering provider.*

**Provider Types**

Under federal regulations, a "health care provider" is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law.

**NPI**

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. It is issued by the National Plan and Provider Enumeration System-NPPES. It is a 10-digit numerical identifier that identifies an individual provider or a healthcare entity. An NPI number is shared with other providers, employers, health plans, and payers for billing purposes.

There are two type of NPI Providers

* **Type1 NPI:** Type1 individuals includes individuals, such as sole proprietors, dentists, physicians and surgeons. A provider is eligible for single NPI.
* **Type2 NPI:** Type2 NPI are organizations and may include acute care facilities, health systems, hospitals, physician groups, assisted living facilities and healthcare providers who are incorporated.

**CPT code**

CPT (Current Procedural Terminology) codes are codes used in the US healthcare system to describe medical procedures, services, and tests. They are five-digit numerical codes used to identify specific procedures and services provided by healthcare providers to patients. CPT codes are standardized, which allows healthcare providers and insurance companies to understand and agree on the services rendered and the payment for those services. They play a crucial role in the medical billing and insurance reimbursement process.

**ICD**

ICD (International Classification of Diseases) codes are codes used in the US healthcare system to describe and classify diseases, disorders, symptoms, and other health conditions. They are standardized codes that allow healthcare providers and insurance companies to understand and agree on the diagnosis of a patient's health condition. The ICD codes are used for health management and health statistics, as well as for insurance reimbursement purposes. The most current version of ICD codes used in the US is the ICD-10, which was adopted in October 2015 and replaced the previous ICD-9 code set. The ICD codes are maintained and updated by the World Health Organization (WHO).

**ICD versions**

The US healthcare system uses the following versions of the International Classification of Diseases (ICD) codes:

**-ICD-9:** This was the previous version of the ICD codes used in the US until it was replaced by ICD-10 in October 2015.

**-ICD-10:** This is the current version of the ICD codes used in the US. It provides a more comprehensive and detailed system for classifying and describing diseases, disorders, symptoms, and other health conditions, and it includes expanded codes for medical and surgical procedures. The ICD-10 codes are used for insurance reimbursement purposes, health management and health statistics, and for tracking and monitoring trends in disease and health conditions.

* ICD-10-PCS- The procedure classification system developed by the Centers for Medicare & Medicaid Services (CMS) for use in the U.S. for inpatient hospital settings only. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM coding system uses 3 or 4 numeric digits.
* ICD-10-CM- The diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all United States (U.S.) health care treatment settings. Diagnosis coding under this system uses 3–7 alpha and numeric digits and full code titles, and will be replacing the current ICD-9-CM code set.

**Q. Why we switch from ICD-9 to ICD-10?**

The switch from ICD-9 to ICD-10 was made because ICD-9 was becoming outdated and limited in its ability to classify modern medical practices and diseases. ICD-10 provides a more comprehensive and specific system for classifying diagnoses and procedures, which is important for accurate tracking and reporting of health information. This supports improved quality of care, research, and reimbursement purposes.

**Q. Is ICD-10-PCS different from CPT?**

Yes, ICD-10-PCS and CPT are different. ICD-10-PCS (Procedure Coding System) is used for classifying inpatient procedures, whereas CPT (Current Procedural Terminology) is used for classifying outpatient procedures. ICD-10-PCS is used in the United States for reporting hospital inpatient procedures, while CPT is used by physicians, health care facilities, and insurance companies for reporting medical procedures and services. Both codes provide a standardized system for reporting procedures, but they are separate and distinct systems.

**Q. If a procedure is being performed by the doctor and a CPT code is being used to represent the procedure, why does the procedure need to be translated into ICD-10-PCS for the hospital?**

Hospitals do not report inpatient procedures with CPT, like a physician does. They use a completely different coding system. On October 1, 2015, that coding system will be ICD-10-PCS. Therefore, procedures are will not be translated back and forth from CPT to ICD-10-PCS. If a procedure is performed as an inpatient procedure in a hospital AND the claim (a CMS 1450) is being submitted by the hospital, the code to describe the procedure would come from the ICD-10-PCS code set. The surgeon will submit a CMS 1500 claim to 3rd party payers and that claim will contain CPT procedure codes.

**Q. What ICD-10 codes are billable?**

ICD-10 codes that are billable are those codes that accurately describe the diagnosis, symptoms, or medical condition of a patient and that are used to support a claim for payment by a healthcare provider. The codes must meet the requirements of the specific payer, including meeting medical necessity criteria and not being considered experimental or investigational.  
  
For example, if a patient is diagnosed with Type 2 diabetes, the billable ICD-10 code for that diagnosis would be E11.9 (Type 2 diabetes mellitus without complications). This code accurately describes the patient's condition and can be used to support a claim for payment from the patient's insurance company.  
  
It's important to note that while this code may be considered billable by one insurance company, another company may have different requirements or limitations on coverage. Therefore, it's important for healthcare providers to check with the patient's insurance plan to confirm which ICD-10 codes are billable for that particular patient.

**Q. How many ICD-10 Combinations are there?**

As with ICD-9-CM, ICD-10-CM is maintained by the National Center for Health Statistics. The system consists of **more than 68,000** codes, compared to approximately 13,000 ICD-9-CM codes.

**Note:** The World Health Organization (WHO) updates the ICD codes periodically and releases new versions. The US healthcare system is expected to adopt future versions of the ICD codes as they become available. In 2023 1176 New code are added in ICD-10.

**Q. What are Header Codes?**

These codes are identified by CDC (Centers for Disease Control and Prevention) as **Header Codes** which are not valid for HIPAA transactions or considered proper coding. There are about 70,000 HIPAA-valid ICD-10 codes. And there are approximately 22,000 additional header codes. Header codes require more digits to indicate the appropriate level of specificity. The increased level of specificity is expected to provide significantly better data analysis opportunities for the health-care industry.

We will deny header codes with the following CORE (Committee on Operating Rules for Information Exchange) approved messages:

* **Claim Adjustment Reason Code (CARC) 16:** Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
* **Remittance Advice Remark Code (RARC) M76:** Missing/incomplete/invalid diagnosis or condition.

**Example:**

Z34-Encounter for supervision of normal pregnancy—**Header Code**

Z340-Encounter for supervision of normal first pregnancy—**Header Code**

Z3400-Encounter for supervision of normal 1st pregnancy. Unspecified Trimester—**Unspecified Code**

Z3401- Encounter for supervision of normal 1st pregnancy.1st trimester—**ICD-10**

**What is the relation between ICD and CPT in US healthcare system**

* ICD (International Classification of Diseases) codes and CPT (Current Procedural Terminology) codes are two different coding systems used in the US healthcare system.
* ICD codes are used to describe and classify diseases, disorders, symptoms, and other health conditions for health management and health statistics, as well as for insurance reimbursement purposes.
* CPT codes, on the other hand, are used to describe medical procedures, services, and tests provided by healthcare providers to patients. They are used for billing and insurance reimbursement purposes, and help to standardize the description of the services rendered so that healthcare providers and insurance companies can understand and agree on the services provided and the payment for those services.

The two coding systems are related because they both play a role in the medical billing and insurance reimbursement process. For example, when a patient receives a medical service or procedure, the healthcare provider will use both an ICD code to describe the patient's diagnosis and a CPT code to describe the service or procedure provided. The combination of the ICD and CPT codes is used to determine the payment for the service or procedure.

**HCPCS**

HCPCS (Healthcare Common Procedure Coding System) is a coding system used in the US healthcare system to describe medical procedures, services, and supplies, as well as durable medical equipment (DME) and other medical equipment used in the diagnosis and treatment of patients.  
  
HCPCS codes are similar to CPT (Current Procedural Terminology) codes and are used for billing and insurance reimbursement purposes. HCPCS codes provide a standardized way for healthcare providers and insurance companies to describe and understand the medical services, supplies, and equipment provided to patients. The HCPCS codes are maintained and updated by the Centers for Medicare & Medicaid Services (CMS) and are used primarily for billing Medicare and Medicaid programs, but may also be used by private insurance companies and other healthcare payers.  
  
The HCPCS coding system is divided into two levels, Level I and Level II. Level I HCPCS codes are comprised of CPT codes, which are maintained by the American Medical Association (AMA), and are used to describe medical procedures and services. Level II HCPCS codes are used to describe medical supplies, equipment, and other services that are not included in the CPT codes. Level II HCPCS codes are updated annually and provide additional detail and specificity compared to Level I codes.

**Dx Pointers**

Dx pointers, also known as diagnosis pointers, are used in the US healthcare system to indicate the relationship between a medical procedure or service and the patient's diagnosis. Dx pointers are used in medical billing and insurance reimbursement processes to help healthcare providers and insurance companies understand the context of the medical service provided to the patient.  
  
**For example,** when a healthcare provider submits a claim to an insurance company for a medical procedure, they would include both the CPT (Current Procedural Terminology) code for the procedure and the ICD (International Classification of Diseases) code for the patient's diagnosis. The Dx pointer is a letter or symbol used to indicate the relationship between the two codes.  
  
**For example,** if a patient is diagnosed with a broken arm (ICD code S52.02) and undergoes a cast application procedure (CPT code 29515), the Dx pointer would indicate that the cast application procedure is being performed to treat the broken arm. The Dx pointer would be included in the claim submitted to the insurance company to help them understand the context of the medical service being provided.  
  
**Note:** The specific Dx pointers used in the US healthcare system may vary depending on the medical billing and insurance reimbursement processes used by different healthcare providers and insurance companies.

**Accept Assignment**

Accept assignment in the US healthcare system refers to a healthcare provider's agreement to accept the Medicare-approved amount as payment in full for services provided to a Medicare beneficiary. When a healthcare provider accepts assignment, they agree to accept the Medicare payment as payment in full, and cannot bill the patient for any additional amounts.  
  
**For example**, if a healthcare provider provides a service to a Medicare beneficiary and the Medicare-approved amount for that service is $100, the healthcare provider who accepts assignment would bill Medicare for $100 and accept that payment as payment in full for the service provided. The healthcare provider cannot bill the patient for any additional amounts.  
Accept assignment is an important concept in the US healthcare system because it helps to ensure that Medicare beneficiaries receive their medical services at a predictable cost, and that healthcare providers are paid fairly and consistently for their services. Healthcare providers who do not accept assignment may charge patients more than the Medicare-approved amount, which can lead to unexpected out-of-pocket costs for the patient.

**Modifiers**

Modifiers in the US healthcare system are two-digit codes added to CPT (Current Procedural Terminology) codes to provide additional information about a medical service or procedure. Modifiers are used to describe specific aspects of a medical service that may affect the payment for that service, such as the circumstances under which the service was provided, the location of the service, or the type of service provided.  
  
**For example,** if a healthcare provider performs a procedure with a CPT code of 99201, but the patient has multiple medical conditions that require additional time and effort on the part of the healthcare provider, the healthcare provider may add modifier 25 to the CPT code. Modifier 25 indicates that a significant, separately identifiable evaluation and management (E/M) service was provided on the same day as a procedure, and may result in a higher payment for the service provided.  
  
Another example of a modifier is modifier 59, which is used to indicate that a service was distinct or separate from other services performed during the same encounter. For example, if a healthcare provider performs two procedures during the same visit, but the procedures are not typically performed together and are separately billable, the healthcare provider may add modifier 59 to one of the CPT codes to indicate that the service is distinct or separate.  
  
*Modifiers play an important role in the US healthcare system by providing additional information about medical services that can affect payment for those services. This information helps insurance companies and other healthcare payers make more informed decisions about reimbursement for medical services, and helps ensure that healthcare providers are paid fairly and consistently for the services they provide.*

**Clearing Houses**

Clearinghouses in the US healthcare system are intermediaries between healthcare providers and insurance companies that process and manage medical claims. They are responsible for verifying the validity of the claims, ensuring that the codes and information used on the claims are accurate, and transmitting the claims to the insurance companies for payment. There are two types of clearinghouses:  
  
**Web-based clearinghouses** - These clearinghouses are web-based platforms that allow healthcare providers to submit electronic claims directly to insurance companies.  
  
**Data-based clearinghouses** - These clearinghouses collect and aggregate medical claims from multiple healthcare providers, and then transmit the claims to insurance companies for payment.  
  
An example of a clearinghouse is Change Healthcare. Change Healthcare is a data-based clearinghouse that receives claims from healthcare providers, validates the claims, and transmits them to insurance companies for payment. The clearinghouse uses advanced technologies such as artificial intelligence and machine learning to ensure the accuracy and efficiency of the claims processing. The healthcare providers receive feedback on the status of their claims and receive payments from insurance companies through the clearinghouse. for example, if a patient fills out forms as Jenny but their full legal name is Jennifer, the clearing houses make sure those records get combined and not added as a new patient. They will also check for duplicate or incorrect codes that tell the system what to bill for.

**Q. How does a Medical billing Clearing house work?**

When healthcare providers install medical billing software, each claim becomes a file knows as an **ANSI-X12-837**. Each file is then uploaded to the clearing house and scrubbed for errors. Finally, the error-free file is transmitted to the insurance company for processing. This entire process takes place over secure electronic connections per the guidelines of the HIPPA.

**Q. What are the benefits of using a medical billing clearing house?**

There are many advantages to using a medical billing clearinghouse for your claims process. Here are just a few key benefits that come from leveraging this option:

* Greater Convenience
* Better Legibility
* Improved Processes
* Increased Administrative Efficiency
* More Accurate Documentation
* Fewer Errors and returned claims
* Improved ROI

Clearinghouses play a crucial role in the US healthcare system by serving as intermediaries between healthcare providers and insurance companies. They process and manage the large volume of administrative and financial transactions involved in submitting and paying health insurance claims. Clearinghouses help ensure that claims are accurate, standardized, and comply with industry standards and regulations, making the claims process more efficient and reducing errors and delays in payment. They also provide data analytics and other value-added services to healthcare providers, insurance companies, and government agencies to help improve the overall functioning of the healthcare system.

**Q. Why do we need Clearing houses?**

* Clearing house software can identify errors in seconds and alert your staff immediately. Which allows them to quickly adjust while the information is still fresh in their mind.
* A clearing house stores individual payer information so that data related to that payer doesn’t have to be re-entered every single time, making the submission process much faster.
* You have the option to send all your claims at once instead of submitting a separate file for each and every payer.
* In the case of an emergency event, a clearing house can provide you with a back-up copy of any important billing data you submitted and then lost.
* You save money on printing ink, stamps, mailing supplies and other expenses associated with paper correspondence.

**Patient Demographics**

Patient demographics are a patient’s basic information. Practices collect patient demographics to provide higher-quality care and streamline the [medical billing and coding](https://www.businessnewsdaily.com/16238-medical-billing-coding.html) process. These data overlap strongly with [marketing demographics](https://www.businessnewsdaily.com/15779-small-business-marketing-demographics.html), though they aren’t exactly the same. Whereas marketers use demographics to determine which consumers might be worth their attention, practitioners use patient demographics to help those already in front of them and bill payers for their services.

Patient demographics almost always include the following information:

* Full legal name
* Date of birth
* Biological sex
* Gender
* Contact information, including address
* Ethnicity
* Race
* Allergies
* Previous medical history
* Insurance ID number
* SSN

**Q- Why are Patient demographics important?**

Patient demographics matter because they:

* Guide the billing process
* Streamline patient communications
* Improve patient care
* Increase Cultural Competency

**EDI**

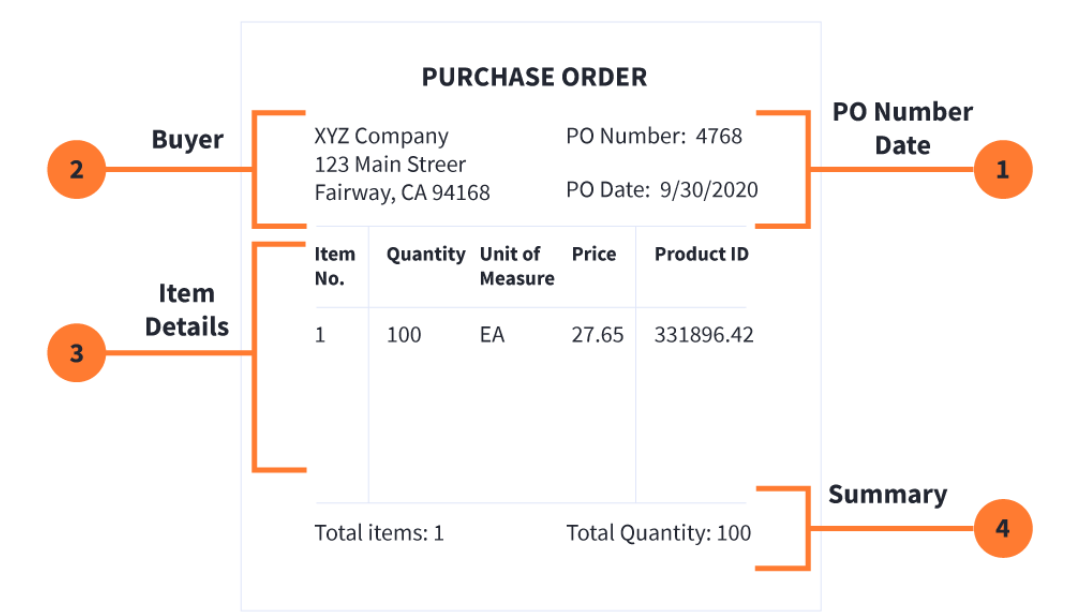
Electronic Data Interchange (EDI) is the electronic exchange of standardized business documents between companies in the US healthcare system. It is used to facilitate the transaction of information between healthcare providers, insurance companies, and government agencies.  
  
Some of the common EDI transactions in the US healthcare system include:

* **Healthcare claim transaction set (837)**. It allows healthcare providers and patients to submit healthcare claim information and encounter information.
* **Retail pharmacy claim transaction**. It allows healthcare professionals and regulatory agencies to submit retail pharmacy claims. It also lets them transmit claims for retail pharmacy services and billing payment information to payers.
* **Healthcare claim payment/advice transaction set (835)**. It is used by insurers to make payments and send Explanation of Benefits (EOB) remittance advice to healthcare providers.
* **Benefits enrollment and maintenance set (834)**. It is used by employers, unions, government agencies, insurance agencies, associations, or healthcare organizations paying claims. Its aim is to enroll members in a healthcare benefit plan.
* **Payroll deducted and other group premium payment for insurance products (820)**. This transaction serves to make premium payments for insurance products and is used by healthcare institutions to send information to financial organizations.
* **Healthcare eligibility/benefit inquiry (270)**. This transaction set is used by healthcare institutions to transmit inquiries for healthcare benefits and subscriber eligibility to financial institutions and government agencies.
* **Healthcare eligibility/benefit response (271)**. Its main purpose is to respond to request inquiries about the healthcare benefits and eligibility associated with a subscriber or dependent. Like the previous transaction, it is used by healthcare institutions to transmit information to financial institutions and government agencies.
* **Healthcare claim status request (276)**. This transaction is used by healthcare providers to request or verify the status of healthcare previously submitted to a payer, such as an insurance company.
* **Healthcare claim status notification (277)**. It serves for reporting on the status of claims (EDI 837 transactions) previously submitted by providers. EDI 277 is used by healthcare payers and insurance companies.
* **Healthcare service review Information (278)**. It is used by hospitals to request an authorization from a payer, such as an insurance company.

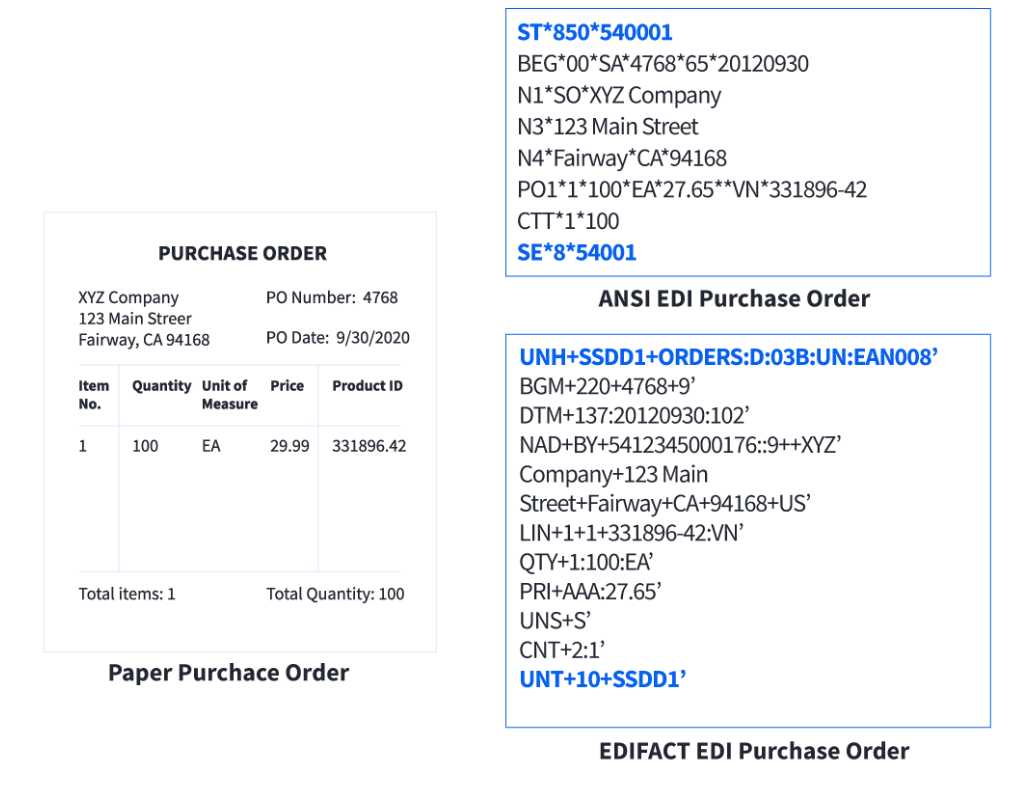
The EDI transactions list also includes EDI Functional Acknowledgement Transaction Set (997). But it doesn’t cover any semantic meaning of the information encoded in the transaction sets. It is only necessary for X12 transaction set processing.

**Segments**

If you were filling out information on a purchase order, you would expect to see groups of related data. For example, look at the diagram below of a paper purchase order in which only one item is being ordered. Note that there are four sections, each providing a different set of information:



The graphic below shows a sample purchase order in printed form and how it would look once it’s translated into the [**ANSI**](https://www.edibasics.com/edi-resources/document-standards/ansi/)and [**EDIFACT**](https://www.edibasics.com/edi-resources/document-standards/edifact/)EDI formats.



**Q. What’s the difference between 837P and 837I?**

* EDI P (Professional) refers to EDI transactions that are used to submit claims for payment to insurance companies or Medicare/Medicaid from Physicians, suppliers and non-institutional providers for both in-patient and out-patient
* EDI I (Institutional) refers to EDI transactions that are used to submit claims for payment from institutional providers, such as hospitals or long-term care facilities, to insurance companies or Medicare/Medicaid.

**Q. What is Pre-Authorization in EDI?**

Pre-authorization in EDI refers to the process of obtaining approval from a payer (such as an insurance company) for a proposed healthcare service or treatment before it is performed. The goal of pre-authorization is to ensure that the proposed service is medically necessary and covered by the patient's insurance policy, and to estimate the cost of the service so that the patient and the healthcare provider are aware of any out-of-pocket expenses that may be incurred.

An example of pre-authorization using EDI:

* A healthcare provider evaluates a patient and determines that a specific medical procedure is necessary.
* The provider uses the EDI 278 transaction to submit a request for pre-authorization of the medical procedure to the patient's insurance company. The request includes information such as the patient's demographic information, diagnosis codes, and the proposed treatment plan.
* The insurance company reviews the information and uses the EDI 278 transaction to respond to the provider with the results of the pre-authorization review. The response may include information such as whether the medical procedure has been approved or denied, any conditions that must be met for approval, and the estimated cost of the procedure.
* If the medical procedure is approved, the healthcare provider can proceed with the treatment, confident that it will be covered by the patient's insurance policy. If the procedure is denied, the provider and patient can work together to determine alternative courses of action.

**Q. What’s the difference between 278I and 278N?**

Two common variants of the EDI 278 transaction are the 278I (Information Only Request) and the 278N (Request for Approval or Denial of Services).

The 278I is used to request general information about a healthcare service, such as the coverage criteria, policies, and procedures for pre-authorization. The 278I is typically used by healthcare providers to gain a better understanding of the payer's requirements and processes for pre-authorizing healthcare services.

The 278N, on the other hand, is used to request specific approval or denial of a proposed healthcare service. The 278N includes all the necessary information about the proposed service, including patient demographic information, diagnosis codes, and the proposed treatment plan. The payer reviews the information in the 278N and uses the EDI 278 transaction to respond with the results of the review, including whether the service has been approved or denied, any conditions that must be met for approval, and the estimated cost of the service.

In summary, the 278I is used to request general information, while the 278N is used to request specific approval or denial of a proposed healthcare service.

**Q. What’s the difference between Referral, Authorization???**

In the US healthcare system, referral, authorization, and pre-authorization are terms that describe different aspects of the process of obtaining approval for healthcare services.

Here's a brief explanation of each term, along with an example:

* Referral: A referral is a recommendation from one healthcare provider to another, indicating that a patient needs to be seen by a specialist or receive a specific type of care. For example, a primary care physician may refer a patient to a specialist for a specific medical condition.
* Authorization: Authorization refers to the process of obtaining approval from a payer (such as an insurance company) for a proposed healthcare service or treatment. This process confirms that the service is medically necessary and covered by the patient's insurance policy, and also provides the patient and healthcare provider with an estimate of the cost of the service.

An example of the referral, authorization, and pre-authorization process:

* A patient sees their primary care physician, who determines that the patient needs to see a specialist for a specific medical condition.
* The primary care physician refers the patient to a specialist using the EDI 278 transaction.
* The specialist uses the EDI 278 transaction to submit a request for pre-authorization of a specific medical procedure to the patient's insurance company.
* The insurance company reviews the information in the EDI 278 transaction and uses the EDI 278 transaction to respond with the results of the pre-authorization review, including whether the service has been approved or denied, any conditions that must be met for approval, and the estimated cost of the service.
* If the medical procedure is approved, the specialist proceeds with the treatment, confident that it will be covered by the patient's insurance policy.

**Q. What’s the difference between PAN and Referral?**

In the US healthcare industry, a PAN (Pre-Authorization Number) and a referral are two different concepts that are used to manage patient care and determine reimbursement for healthcare services.

A PAN is a unique number assigned by a payer, such as an insurance company, to pre-approve a specific healthcare service or treatment for a patient. The purpose of a PAN is to ensure that the patient's insurance coverage will be honored for the specific service, and to confirm that the service is medically necessary and meets the criteria for coverage under the patient's insurance plan.

For example, if a patient requires a costly medical procedure, the provider may need to obtain a PAN from the patient's insurance company in order to confirm that the procedure is covered and that the patient will not be responsible for the full cost of the service.

A referral, on the other hand, is a process by which a healthcare provider refers a patient to another provider or specialist for a specific service or treatment. The purpose of a referral is to ensure that the patient receives the appropriate level of care for their specific needs, and to coordinate the care that is provided to the patient.

For example, if a patient has a complex medical condition that requires the expertise of a specialist, the primary care provider may refer the patient to a specialist for further evaluation and treatment.

In summary, a PAN is used to pre-approve a specific service for coverage, while a referral is used to refer a patient to another provider for a specific service or treatment. Both concepts are important in the US healthcare industry, and are used to manage patient care and ensure that patients receive the appropriate level of care for their specific needs.

EDI helps streamline the healthcare claims process and reduces errors and delays associated with manual data entry and processing. It also ensures that sensitive patient information is securely transmitted between healthcare stakeholders.

There are several EDI protocols and communication standards used in the US healthcare system. Some of the most common ones are:

* **ANSI X12:** This is a widely used EDI standard that was developed by the Accredited Standards Committee (ASC) X12. It covers a wide range of EDI transactions including claims submissions, remittance advice, eligibility and benefit inquiries, and more.  
  **Example:** The ANSI X12 837 is used to submit healthcare claims electronically.
* **NCPDP:** Developed by the National Council for Prescription Drug Programs, NCPDP is used for EDI transactions related to pharmacy claims, drug benefits, and prescription orders.  
  **Example:** The NCPDP Telecommunication Standard is used to electronically transmit pharmacy claims information.
* **HL7:** This standard was developed by the Health Level Seven International and is used for the exchange of health information between healthcare providers and other stakeholders.  
  **Example:** The HL7 2.x series is used to transfer clinical and administrative data between healthcare organizations.
* **EDIFACT:** This is an international EDI standard developed by the United Nations and is used in several countries outside of the US.

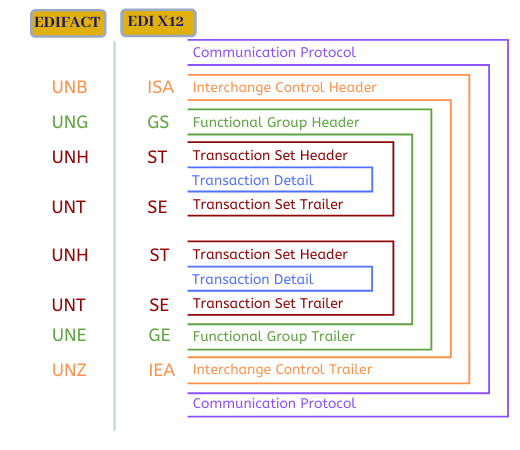
**Example:** The EDIFACT INVOIC is used to send invoices electronically between business partners.  
  
The use of these standardized protocols ensures that EDI transactions are consistent, reliable, and secure, and helps reduce the risk of errors and delays in the healthcare claims process.

**Q. What’s the difference between EDIFACT and ANSI?**

ANSI (American National Standards Institute) and EDIFACT (Electronic Data Interchange for Administration, Commerce and Transport) are two standardized formats that are used for the electronic exchange of information between organizations.

ANSI is a non-profit organization that develops and publishes standards in a variety of industries, including healthcare. In the healthcare industry, ANSI has developed the ANSI X12 standard, which is a set of electronic data interchange (EDI) standards that are used to transmit information between healthcare organizations. The ANSI X12 standard includes specific data elements and codes that are used to transmit information such as claims, remittances, and enrollments.

EDIFACT, on the other hand, is an international EDI standard that is used for the electronic exchange of information between organizations in a variety of industries, including healthcare. EDIFACT defines the format and structure of EDI transactions and includes specific data elements and codes that are used to transmit information such as purchase orders, invoices, and shipping notices.



In summary, ANSI and EDIFACT are two standardized formats that are used for the electronic exchange of information between organizations. ANSI has developed the ANSI X12 standard for the healthcare industry, while EDIFACT is an international EDI standard that is used in a variety of industries, including healthcare.

**HCFA 1500**

The HCFA (Health Care Financing Administration) 1500 is a standardized form used for submitting medical claims in the United States. The form, which is also known as the CMS-1500, is used by healthcare providers to bill insurance companies for medical services provided to patients.  
  
The HCFA 1500 form contains key information about the patient, including their name, date of birth, and insurance information, as well as information about the services provided, such as diagnosis codes and treatment codes. The form also includes a section for the provider to specify the charges for each service.  
  
The HCFA 1500 form has been replaced by the newer CMS-1500 form, which is similar in content but has been updated to reflect changes in medical coding and billing practices.  
  
Here is an example of how the HCFA 1500 form could be used in a typical healthcare scenario:  
  
A patient visits a doctor for treatment of a medical condition. The doctor provides a diagnosis and treatment, and the patient's insurance information is obtained. The doctor's office then uses the HCFA 1500 form to bill the insurance company for the services provided. The form is filled out with the patient's information, the diagnosis and treatment codes, and the charges for each service. The completed form is then submitted to the insurance company for payment.  
  
The use of the HCFA 1500 form helps streamline the medical billing process by providing a standardized format for submitting claims, and reduces the risk of errors and delays in payment.

**ERA**

Electronic Remittance Advice (ERA) is a type of electronic document used in the US healthcare system to communicate payment information from insurance companies to healthcare providers. It is generated after an insurance company processes a claim submitted by a provider and contains information about the payments made and any adjustments or denials made to the claim.  
  
The ERA provides a detailed breakdown of the claim, including the allowed amount, the amount paid, and the patient's responsibility, if any. It also includes information about any deductibles, coinsurance, and copayments, as well as any explanations of benefits (EOBs) or reasons for adjustments or denials.  
  
Here is an example of how ERA could be used in a typical healthcare scenario:  
  
A healthcare provider submits a claim to an insurance company for services provided to a patient. The insurance company processes the claim and generates an ERA. The ERA is transmitted electronically to the provider and includes information about the payment made, any adjustments or denials, and any remaining patient responsibility. The provider can use this information to reconcile their accounts and ensure that they have received the correct payment for the services provided.  
  
The use of ERA helps streamline the medical billing process and reduces the need for manual reconciliation of payments, as well as improves accuracy and reduces errors in the process.

**EOB**

An Explanation of Benefits (EOB) is a document used in the US healthcare system to provide information about the payment made by an insurance company for a medical claim. The EOB serves as a detailed breakdown of the insurance company's payment and includes information about any deductibles, coinsurance, copayments, and other charges.  
  
The EOB is typically sent to the patient or the healthcare provider after the insurance company processes a claim. It provides a clear understanding of the charges and the payment made, and helps both the patient and the provider keep track of their financial obligations and responsibilities.

Here is an example of how an EOB could be used in a typical healthcare scenario:

A patient visits a doctor and receives medical treatment. The doctor's office submits a claim to the insurance company for payment. After processing the claim, the insurance company generates an EOB and sends it to the patient. The EOB shows the charges for the medical services provided, the amount covered by the insurance, and any amounts owed by the patient, such as copayments, deductibles, or coinsurance.  
  
The use of EOB helps increase transparency and clarity in the medical billing process, enabling patients and healthcare providers to understand their financial obligations and responsibilities. It also helps reduce the risk of misunderstandings and disputes related to payment.

***Electronic remittance advice (ERA) is an electronic version of the explanation of benefits (EOB) for claims payments***

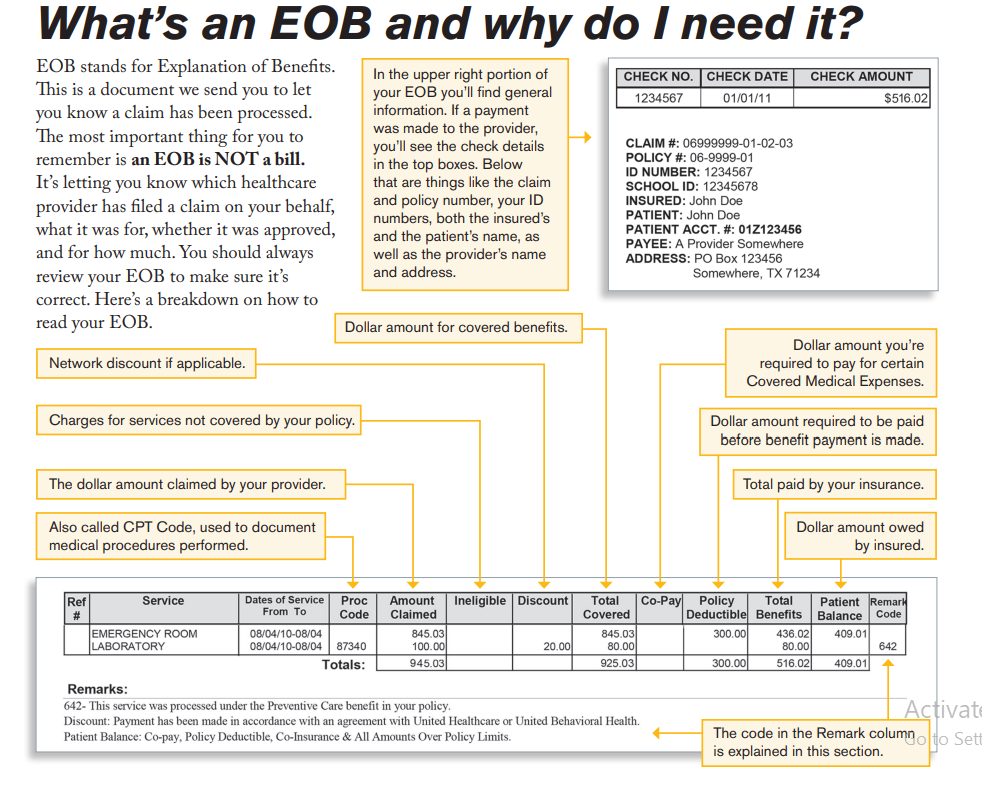
ERA (Electronic Remittance Advice) is a type of electronic payment advice generated by insurance companies to healthcare providers. It provides details about insurance payments for medical claims submitted by healthcare providers and helps the providers reconcile their payments and patient billing.

EOB (Explanation of Benefits) is a document provided by insurance companies to policyholders explaining the details of a particular claim and how the insurance company has processed and paid it. The EOB explains what was covered, what was denied, and the reasons why. It also shows how much the policyholder is responsible for paying and how much was paid by the insurance company.

***In summary, ERA is a document for healthcare providers, while EOB is a document for policyholders.***

**Q. Do EOB have a number?**

The EOB typically includes a unique identifier that is assigned by the payer, such as a claim number, a reference number, or a policy number. This number is used to identify the specific transaction and to track the payment.



**Eligibility**

Eligibility in the US healthcare system refers to a patient's ability to receive medical benefits under a particular insurance plan. Eligibility determines whether a patient is covered for specific medical services, and it is based on a variety of factors, such as the patient's age, location, and enrollment status in an insurance plan.  
  
Eligibility is an important aspect of the healthcare system because it determines a patient's access to medical care and helps healthcare providers understand the extent of a patient's insurance coverage. It is used to determine whether a patient's insurance plan will pay for a particular medical service and whether the patient will be responsible for paying any deductibles, coinsurance, or copayments.  
  
Here is an example of how eligibility could be used in a typical healthcare scenario:  
  
A patient visits a doctor and needs a specific medical test. The doctor's office checks the patient's insurance plan to determine their eligibility for the test. The office then submits a claim to the insurance company for payment. The insurance company checks the patient's eligibility and determines whether the test is covered under the patient's insurance plan and how much the patient will be responsible for paying. If the patient is eligible for the test, the insurance company pays the claim, and the patient is responsible for paying any copayments, deductibles, or coinsurance.  
  
The use of eligibility helps ensure that patients have access to the medical care they need and helps healthcare providers understand the extent of a patient's insurance coverage. It also helps prevent misunderstandings and disputes related to payment and helps ensure that patients receive the correct medical treatment.

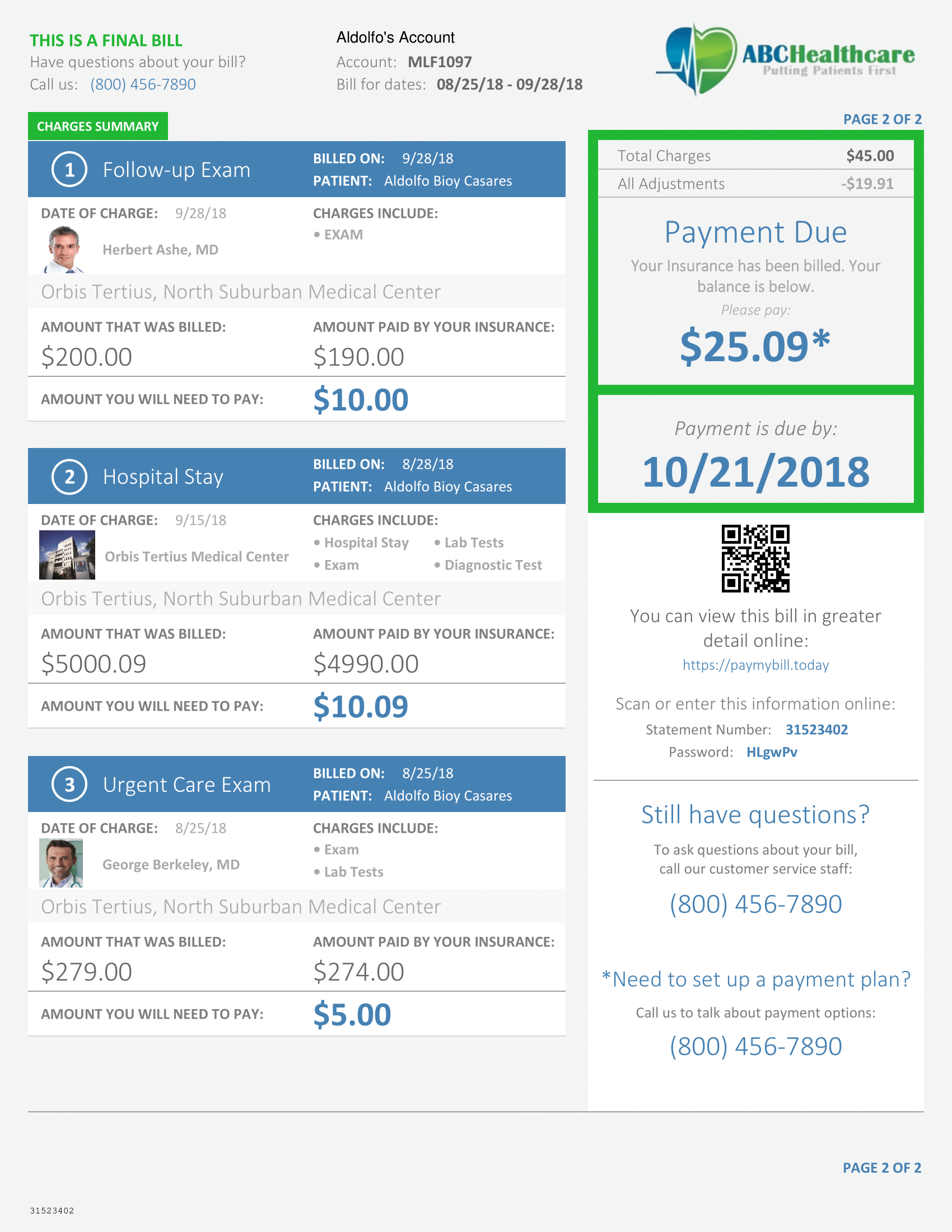
**5010 Standard**

The 5010 standard is a version of the electronic data interchange (EDI) standard used in the US healthcare industry for the exchange of electronic transactions between healthcare providers and insurance companies. It is the successor to the 4010 standard and was introduced to improve the efficiency and accuracy of electronic transactions in the healthcare industry.  
  
The 5010 standard specifies the format and content of electronic transactions, such as claims submissions, remittance advice, and eligibility requests. It includes specific requirements for data elements, code sets, and transaction structure. The 5010 standard ensures that electronic transactions are processed accurately, efficiently, and consistently, reducing the risk of errors, delays, and denied claims.  
  
Here is an example of how the 5010 standards could be used in a typical healthcare scenario:  
  
A healthcare provider submits a claim to an insurance company for payment. The provider uses the 5010 standard to format the electronic transaction, including all the required data elements and code sets. The insurance company receives the claim and processes it using the 5010 standard, which ensures that the transaction is processed accurately, efficiently, and consistently. The insurance company then generates a remittance advice, which is also formatted using the 5010 standard, and sends it back to the provider.  
  
The use of the 5010 standard helps improve the efficiency and accuracy of electronic transactions in the healthcare industry and reduces the risk of errors, delays, and denied claims. It ensures that all stakeholders in the healthcare system, including healthcare providers, insurance companies, and patients, have access to accurate and up-to-date information.

**Patient Statement**

A patient statement in the US healthcare industry is a document that provides a summary of the financial transactions between a patient and a healthcare provider. It typically includes information about the medical services provided, the amounts charged, and any payments made by the patient or by insurance companies. The patient statement is used to communicate the patient's financial obligations and helps the patient understand the charges for their medical treatment.  
  
Here is an **example** of how a patient statement could be used in a typical healthcare scenario:  
A patient visits a doctor and receives medical treatment. The doctor's office generates a bill and submits a claim to the insurance company for payment. The insurance company processes the claim and makes a payment, which is reflected on the patient's statement. The patient statement shows the charges for the medical services provided, the amount covered by the insurance, and any amounts owed by the patient, such as copayments, deductibles, or coinsurance.

The use of patient statements helps increase transparency and clarity in the medical billing process, enabling patients to understand their financial obligations and responsibilities. It also helps reduce the risk of misunderstandings and disputes related to payment and helps ensure that patients receive accurate and up-to-date information about their financial status.



**Contractual Adjustment**

**A Contractual Adjustment is a part of a patient's bill that a doctor or hospital must write-off (not charge for) because of billing agreements with the insurance company.**

Contractual adjustment in the US healthcare system refers to a financial adjustment made to a healthcare provider's reimbursement for a covered service under a healthcare contract. This adjustment occurs when the actual payment for a service is different from the contracted rate due to various reasons such as changes in law, regulatory requirements, or coding and billing errors.

**For example**, if a healthcare provider and an insurance company have a contract that specifies a reimbursement rate of $100 for a certain service, but later it is discovered that the service was coded incorrectly, the insurance company may adjust the payment to the correct amount, which may be lower or higher than the contracted rate. The difference between the contracted rate and the actual payment is known as a contractual adjustment.

This adjustment process is a common practice in the US healthcare system and helps to ensure that healthcare providers are fairly reimbursed for the services they provide and that insurance companies are paying the correct amount for those services.

**Not Everything will have a Contractual Adjustment**

An important thing to remember about Contractual Adjustment’s is that they are only made on services covered by the insurance company.  This means that a patient who requires a certain medical service which the insurance company does not cover will end up paying the full amount charged by the medical provider with no contractual adjustment to limit the cost.

An **example** of a Contractual Adjustment is when a provider charges a practice fee for a certain service of $100.  The contracted rate between the insurance company and the provider for this service is $80, with the insurer paying $64, or 80%, and the remaining 20% of the contracted rate amount paid by the patient.  The $20 difference between the $100 charged by the provider and the $80 collected is adjusted off the patient account as a contractual adjustment.

**Group Codes for the claim Adjustment**

Use the below category codes, when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment that the member is not responsible for, or when the provider’s charge exceeds the reasonable and customary amount for which the patient is responsible.

* **CO-Contractual Obligations:** This group code should be used when a joint contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write off for the provider and are not billed to the patient.
* **OA-Other Adjustments:** This group code should be used when no other group code applies to the adjustment.
* **PI-Payer Initiated Reductions:** This group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer.
* **PR-Patient Responsibility:** This group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group code would typically be used for deductible and copay adjustments.

**Q. Are write-off and contractual adjustments the same?**

A contractual adjustment is the amount that the carrier agrees to accept as a participating provider with the insurance carrier. A write off is the amount that cannot be collected from patient due to several issues. Documentation is required for any patient balance adjustment for auditing purposes.

**Q. Difference between CO, OA, PI and PR in US Health care Industry?**

In the context of US health care, CO, OA, PI, and PR are acronyms used to describe different types of contractual adjustments between healthcare providers and payers (such as insurance companies).

* **CO refers to a "Contractual Obligation**," which means that a healthcare provider is required to accept the reimbursement rate set by the payer, regardless of the actual cost of the service provided. For example, if a hospital has a CO with a payer for a specific procedure, the hospital must accept the predetermined rate set by the payer for that procedure, even if the hospital's actual cost for that procedure is higher.
* **Other Allowances (OA):** This type of adjustment is made for reasons that are not covered by a Contracted Adjustment (CO), such as billing errors or duplicate claims. OA adjustments can be made by either the provider or the payer and they may result in a reduction or increase in the reimbursement amount. For example, if a provider accidentally submits a duplicate claim for a medical service, the payer may initiate an OA adjustment to correct the error and reduce the reimbursement amount.
* **Payer Initiated Reduction (PI):** This type of adjustment is initiated by the payer and is made for a variety of reasons, including the discovery of overpayments, the implementation of new payment policies, or the adjustment of claims for services that were deemed medically unnecessary. PI adjustments typically result in a reduction in the reimbursement amount paid to the provider. For example, if a payer discovers that they overpaid a provider for a medical service, they may initiate a PI adjustment to recoup the overpayment.
* **PR** refers to a "**Patient Responsibility**" adjustment, which is the portion of the cost of a service that the patient is responsible for paying. This could include copays, deductibles, or coinsurance. For example, if a patient has a $30 copay for a doctor's visit, the PR adjustment would be $30

Example:

A patient visits a healthcare provider for a medical service that has an allowed amount of $100. The provider's cost for the service is $110, and the patient is responsible for a $20 copayment. In this scenario, the payer might make the following adjustments to the claim:

* CO adjustment: $10 (to account for the difference between the provider's cost and the allowed amount)
* PR adjustment: $20 (to account for the patient's copayment)

The total reimbursement amount paid to the provider would then be $70 ($100 allowed amount - $10 CO adjustment - $20 PR adjustment).

In summary, CO, OA, PI, and PR are all different types of contractual adjustments used in the US health care system to determine the reimbursement rate for healthcare services and the responsibilities of healthcare providers and patients.

**Q. What is PR.01 and PR.02 in case of contractual adjustment?**

PR.01 and PR.02 are codes used in the context of contractual adjustments in the US healthcare system to indicate the patient's responsibility for paying a portion of the cost of a healthcare service or product. These codes are typically used in conjunction with claim submissions to indicate the amount that the patient is responsible for paying.

**PR.01** is a code that indicates the patient is responsible for a copayment, which is a fixed dollar amount that the patient must pay at the time of service. This code is used to indicate that the patient is responsible for paying a portion of the cost of the service, as determined by their insurance plan.

**PR.02** is a code that indicates the patient is responsible for a coinsurance, which is a percentage of the cost of a healthcare service that the patient must pay, after the deductible has been met. This code is used to indicate that the patient is responsible for paying a portion of the cost of the service, as determined by their insurance plan.

It is important to note that these codes are only one part of the information used in the adjustment process, and they are typically used in conjunction with other codes and information to determine the total reimbursement amount paid to the provider. The specific codes and information used will depend on the terms of the patient's insurance plan and the type of service that was provided.

**Cross Over Claim**

A crossover claim in the US healthcare system refers to a claim that is initially processed by one insurance provider but then shifted to another insurance provider for payment. This occurs when the primary insurance provider determines that the claim should have been paid by a secondary insurance provider.

**For example**, a patient has both a primary insurance provider and a secondary insurance provider. The patient visits the doctor and incurs medical expenses. The primary insurance provider processes the claim and determines that the medical expenses should be covered by the secondary insurance provider. The primary insurance provider sends the claim to the secondary insurance provider for payment, which is known as a crossover claim.

The crossover claim process is designed to streamline the payment process and ensure that the patient receives the appropriate insurance coverage for their medical expenses. The crossover claim process can also help reduce the administrative burden on healthcare providers, who are often responsible for submitting claims to multiple insurance providers.

In conclusion, a crossover claim in the US healthcare system refers to a claim that is processed by one insurance provider but shifted to another insurance provider for payment. This process helps ensure that patients receive the appropriate insurance coverage and helps reduce the administrative burden on healthcare providers.

**Q. Why there is a need of Cross Over claim in US Health care??**

The need for cross-over claims in US medical history arose because of the growing complexity and cost of healthcare. Cross-over claims refer to when a patient's healthcare benefits from one payer (e.g. insurance company) "crossover" to another payer, typically a government program such as Medicare, to help pay for remaining medical expenses not covered by the primary insurance. This process was implemented to help ensure that patients receive necessary medical care, especially for those with chronic or long-term health conditions, without being burdened by excessively high out-of-pocket costs.

**Date of Service (DOS)**

The date of service in the US healthcare system refers to the date when a medical service was provided to a patient. It is an important part of the billing process for medical insurance claims, as it helps determine the patient's insurance coverage and the payment responsibility of the insurance company and the patient.

**For example**, let's say a patient visits a doctor on March 15, 2020, for a routine check-up. The doctor performs several tests and diagnoses the patient with a minor illness. The doctor provides the patient with a prescription for medication and schedules a follow-up visit in two weeks.

The date of service for this visit would be March 15, 2020. The insurance company would use this date to determine the patient's insurance coverage and the payment responsibility for the medical services provided on that day. The insurance company would then process the medical claim for the services rendered on March 15, 2020, based on the date of service.

In conclusion, the date of service is a critical component in the US healthcare system, as it helps determine the insurance coverage, payment responsibility, and the processing of medical insurance claims.

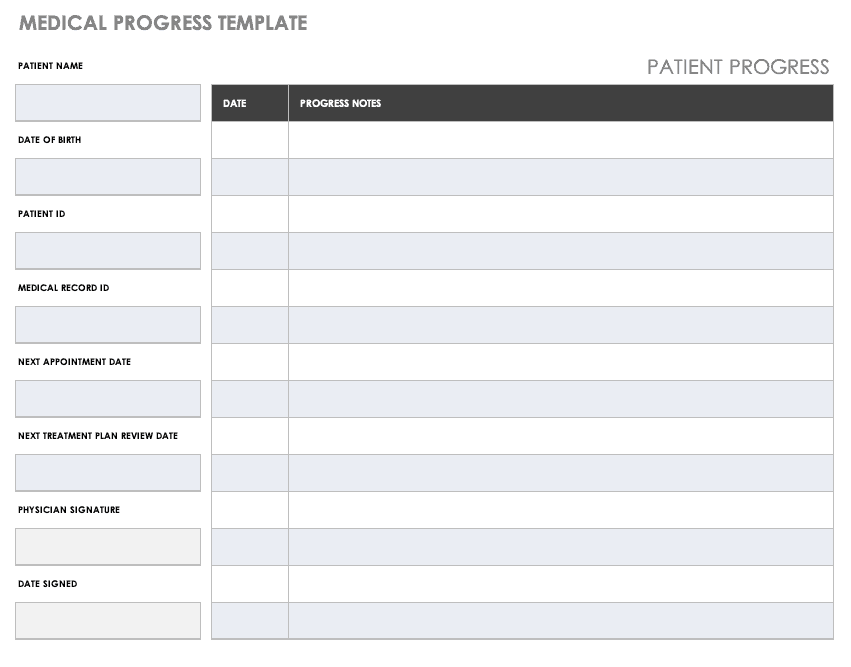
**Day Sheet**

A day sheet in the US healthcare system is a document used by healthcare facilities to track patient activity and transactions throughout the day. It serves as a record of all patient-related activities such as admission, discharge, diagnostic procedures, treatments, medications, and charges.

**For example**, in a hospital setting, the day sheet would include the patient’s name, admission date, diagnosis, and treatment plan. The sheet would also list any procedures performed, medications administered, and the cost of each item. The day sheet is typically updated on a daily basis, allowing the facility to track patient progress and keep an accurate record of all transactions.

At the end of each day, the day sheet is used to summarize all patient activity, including financial transactions, and provide a report of the facility’s daily operations. This information is critical in managing patient care, tracking patient progress, and ensuring that all billing and payment processes are accurate and timely.

In summary, the day sheet is a valuable tool in the US healthcare system that helps healthcare facilities to manage patient care, track patient progress, and ensure accuracy in billing and payment processes.Top of Form



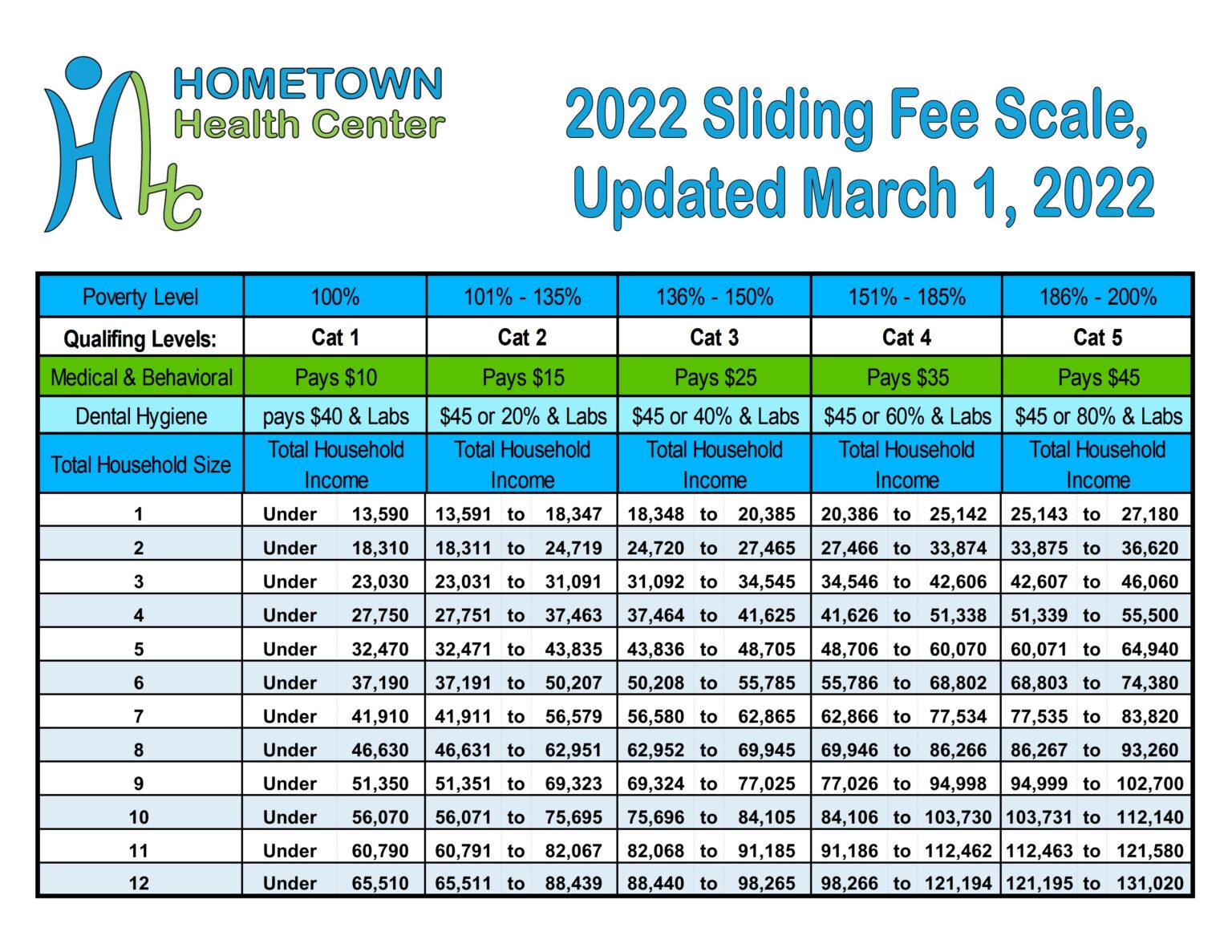
**Fee Schedule**

A fee schedule in the US healthcare system refers to a list of standardized payment amounts for specific medical procedures, services, and treatments. This fee schedule is used by insurance companies, Medicare, and Medicaid to determine the amount of reimbursement that healthcare providers can receive for their services.

**For example**, let's say a patient goes to their doctor for a routine check-up. The doctor performs a physical examination, takes blood pressure readings, and checks the patient's weight. According to the fee schedule, the doctor can receive a payment of $100 for this type of examination. The insurance company will review the fee schedule to determine the payment amount and then send the payment to the doctor. General medical procedure like vaccinations are part of the Fee Schedule but on the other hand surgeries or complex diagnostic procedures like MRI or CT scan are not part of the fee schedule. These procedures are typically billed separately and may not have a set fee and can vary according to the insurance’s plan.

The fee schedule helps to ensure that healthcare providers are reimbursed fairly and consistently for the services they provide. It also helps to control healthcare costs by limiting the amount of money that insurance companies are required to pay for each procedure.

However, there are limitations to the fee schedule in the US healthcare system. Some healthcare providers may believe that the payment amounts are too low to cover the cost of their services, and may choose not to participate in insurance plans that use a fee schedule. Additionally, the fee schedule may not always reflect the actual cost of a procedure, which can result in healthcare providers incurring losses for some services.



**CMS**

CMS stands for the Centers for Medicare and Medicaid Services, which is an agency within the U.S. Department of Health and Human Services. It is responsible for administering two of the largest federal health care programs: Medicare and Medicaid.

Medicare is a federal health insurance program for people who are 65 or older, people with certain disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). Medicaid is a joint federal and state program that provides health coverage for people with low incomes, including families, children, pregnant women, and people with disabilities.

An example of CMS in the U.S. healthcare system can be seen through its role in the administration of Medicare. For example, CMS sets payment policies for hospitals and other health care providers that participate in Medicare, such as how much they will be paid for the services they provide to Medicare beneficiaries. CMS also sets quality standards for the care that Medicare beneficiaries receive, and it oversees the quality of care provided by hospitals, nursing homes, and other health care providers. Additionally, CMS operates the Medicare.gov website, which provides information and resources to help Medicare beneficiaries understand their health care options and make informed decisions.

Overall, CMS plays a critical role in the U.S. healthcare system by administering important federal health programs and ensuring that they are run effectively and efficiently to serve the needs of the American people.

**Collection Ratio**

Collection ratio in the US healthcare system refers to the percentage of the total amount charged to patients or insurance companies that is actually collected by healthcare providers. This ratio is an indicator of the financial performance of healthcare organizations, as it shows how effective they are at collecting payments for services rendered.

**For example**, if a healthcare provider charges $100,000 in total for services and collects $90,000, their collection ratio would be 90%. In other words, 90% of the amount charged was collected, while 10% remained outstanding.

This ratio is important to track because it indicates the financial health of a healthcare organization. If the collection ratio is low, it may mean that patients are not paying their bills, insurance companies are denying claims, or there is a problem with the billing process. In such a scenario, the healthcare organization may have to write off uncollected amounts as bad debt, which can have a significant impact on their bottom line.

A high collection ratio, on the other hand, is a sign of good financial management, as it indicates that the organization is effectively collecting payments from patients and insurance companies. This, in turn, enables the healthcare organization to provide quality care, invest in new technology and equipment, and maintain a healthy financial position.

In conclusion, the collection ratio is a crucial metric for healthcare organizations in the US, as it provides insight into their financial performance and helps them make informed decisions about their business operations

**Net Collection Ratio = Payments / (Account Receivable + Payments + Bad Debt Adjustments)**.

**Group Name in Medical Billing for Insurance**

In medical billing, the "group name" refers to the name of the group of individuals that is covered under a single insurance policy. This group could be a family, a group of employees, or any other type of organization or association.

For example, a group name could be "Smith Family Health Insurance" if it covers a family of four individuals named Smith. Another example could be "ABC Corporation Employee Benefits" if it covers all employees of the ABC Corporation.

The group name is important in medical billing because it is used to identify the specific insurance policy and the individuals who are covered under that policy. This information is used to process insurance claims, determine the insurance benefits available, and ensure that the correct individual is being billed for the services received.

**Group Number**

The group number in medical billing is a unique identifier assigned by the insurance company to each policyholder or group of policyholders who are enrolled in a group insurance plan. It is used to distinguish between different insurance policies and to track the policyholder’s coverage and claims.

For example, if a large corporation enrolls all of its employees in a group health insurance plan, each employee would receive an individual policy with the same group number. This would allow the insurance company to easily track the coverage and claims of each employee, and to process payments and reimbursements efficiently.

In another example, if a family enrolls in a family insurance plan, each member of the family would receive an individual policy with the same group number. This would allow the insurance company to easily track the coverage and claims of each member, and to process payments and reimbursements efficiently.

The group number is usually included on the insurance card along with the policyholder’s name, identification number, and other relevant information. It is important for the policyholder to have their group number readily available when visiting a healthcare provider, as the provider will typically use the group number to verify the policyholder’s insurance coverage and eligibility for certain services.

In summary, the group number in medical billing is a unique identifier used by insurance companies to track the coverage and claims of policyholders enrolled in group insurance plans.

**Q. What’s the difference between Group Name and Group Number?**

In the US healthcare system, the group name and group number are two distinct pieces of information used to identify a group insurance plan.

The group name refers to the name of the organization or employer that has purchased the insurance policy for its employees or members. For example, if a company called "ABC Inc." purchases a group insurance plan for its employees, the group name would be "ABC Inc."

The group number, on the other hand, is a unique identifier assigned by the insurance company to the specific policy purchased by the group. This number is used to track the coverage and claims of the policyholder and to distinguish between different policies. For example, if "ABC Inc." purchases a group insurance policy with an insurance company, the insurance company would assign a unique group number to that policy, such as "12345."

In conclusion, the group name identifies the organization or employer that has purchased the insurance policy, while the group number is a unique identifier assigned by the insurance company to the specific policy purchased by the group.

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**In-Patient**

Inpatient refers to a patient who is admitted to a hospital or healthcare facility and stays overnight for medical treatment or observation. An inpatient receives medical care and services 24 hours a day, usually in a hospital setting. The patient is assigned a bed in a room or ward and is cared for by a team of healthcare providers, including doctors, nurses, and support staff.

For example, if someone is experiencing chest pain and requires a heart catheterization (CPT-93458), they would typically be admitted to the hospital as an inpatient. They would stay overnight in a hospital room and receive round-the-clock care from a healthcare team until it is determined that they are well enough to go home.

**Out-Patient**

Outpatient care refers to medical services that are provided to patients who do not require overnight stay in a hospital or medical facility. It typically involves medical procedures or treatments that can be performed on an outpatient basis, without the need for an overnight stay.

Examples of outpatient care include:

* Doctor’s office visit: This can include a routine check-up, physical examination, or diagnostic testing.
* Diagnostic imaging: Patients may need X-rays, MRI scans, CT scans, or ultrasound scans performed on an outpatient basis.
* Laboratory testing: Patients may need blood tests, urine tests, or other diagnostic tests performed at a laboratory.
* Minor surgical procedures: Outpatient surgery can include procedures such as biopsies, removal of skin growths, or the repair of minor injuries.
* Physical therapy: Patients who have had surgery or are recovering from an injury may receive physical therapy on an outpatient basis.
* Chemical dependency treatment: Patients may receive counseling, support groups, and other treatments for substance abuse or addiction.

The advantage of outpatient care is that patients can receive medical treatment without being hospitalized, which is typically less expensive and more convenient. In addition, patients can often return home the same day, allowing them to recover in their own environment.

**Medicare and its Types**

Medicare is a federally funded health insurance program that provides coverage to eligible individuals who are aged 65 or older, individuals with certain disabilities, and individuals with End-Stage Renal Disease (ESRD). It is administered by the Centers for Medicare and Medicaid Services (CMS).

There are four types of Medicare:

* **Medicare Part A (Hospital Insurance):** This type of Medicare covers inpatient hospital stays, skilled nursing facilities, hospice care, and some home health care services. For example, if a patient requires hospitalization for a serious illness or injury, Medicare Part A will pay for their stay in the hospital.
* **Medicare Part B (Medical Insurance):** This type of Medicare covers outpatient medical services such as doctor visits, diagnostic tests, medical equipment, and preventive services. For example, if a patient needs a laboratory test or X-ray, Medicare Part B will cover the cost of the service.
* **Medicare Part C (Medicare Advantage):** This type of Medicare is a private alternative to traditional Medicare. Medicare Advantage plans provide all of the benefits of Parts A and B, as well as some additional benefits such as prescription drug coverage. For example, if a patient enrolls in a Medicare Advantage plan, they will receive all of their medical care through the private plan and may have lower out-of-pocket costs.
* **Medicare Part D (Prescription Drug Coverage):** This type of Medicare provides coverage for prescription drugs. It is available as a stand-alone plan or as part of a Medicare Advantage plan. For example, if a patient requires prescription drugs for a chronic condition, they can enroll in a Medicare Part D plan to help pay for the cost of their medications.

In summary, Medicare is a comprehensive health insurance program that provides coverage for a wide range of medical services to eligible individuals.

**Medicaid Plan**

Medicaid is a jointly funded, federal-state health insurance program that provides coverage to individuals with low incomes and limited resources. It is administered by the Centers for Medicare and Medicaid Services (CMS) and is designed to help ensure that low-income individuals have access to necessary medical care.

Eligibility for Medicaid is determined by income and resources, as well as by specific categories, such as pregnant women, children, elderly individuals, and individuals with disabilities. In most states, eligibility is based on the federal poverty level (FPL), which is updated annually.

Examples of scenarios where individuals may be eligible for Medicaid include:

* **Pregnant women:** A pregnant woman who earns less than the FPL may be eligible for Medicaid coverage. This can include coverage for prenatal care, delivery, and postpartum care.
* **Children:** Children who live in low-income households may be eligible for Medicaid. This can include coverage for routine health care, immunizations, and preventive services.
* **Elderly individuals:** Individuals who are aged 65 or older and have low incomes may be eligible for Medicaid. This can include coverage for nursing home care, home health care, and other long-term care services.
* **Individuals with disabilities:** Individuals with disabilities who have limited income and resources may be eligible for Medicaid. This can include coverage for medical equipment, rehabilitation services, and home health care services.
* **Individuals in poverty:** Individuals who are living in poverty and do not have access to other health insurance may be eligible for Medicaid. This can include coverage for medical, dental, and mental health services.

Medicaid is an important source of health coverage for low-income individuals, and it helps ensure that they have access to necessary medical care. By providing comprehensive health coverage, Medicaid helps to reduce health disparities and improve overall health outcomes for individuals in need.

**Network Provider**

A network provider in the US healthcare system refers to a healthcare provider that has contracted with a health insurance company or a Medicare Advantage plan to provide medical services to its enrolled patients. The provider agrees to accept a set rate for their services and the insurance company or Medicare Advantage plan agrees to cover the cost of those services.

Examples of network providers include:

* **Primary care physicians:** These are providers who are typically the first point of contact for patients seeking medical care. They can provide preventive care, diagnose and treat illnesses, and refer patients to specialists as needed.
* **Specialists:** These are providers who have specialized training in a particular area of medicine, such as cardiology, oncology, or gastroenterology. They provide specialized medical care to patients and work in collaboration with primary care physicians.
* **Hospitals:** Hospitals are medical facilities that provide inpatient and outpatient medical services, including emergency care, surgery, and rehabilitation.
* Laboratories: Laboratories provide diagnostic testing services, such as blood tests, X-rays, and CT scans.
* **Pharmacies:** Pharmacies dispense prescription medications to patients and provide information about how to take those medications safely and effectively.
* **Home health agencies:** Home health agencies provide medical care and support services to patients in their homes, including nursing care, physical therapy, and home health aides.

By participating in a network, healthcare providers agree to provide medical services to enrolled patients at a lower cost, and insurance companies or Medicare Advantage plans agree to cover the cost of those services. This helps to control the cost of healthcare and ensures that patients have access to necessary medical services. Patients typically have lower out-of-pocket costs when they use network providers, as opposed to providers who are not in their network.

**Out of Network Provider**

An out-of-network provider in the US healthcare system refers to a healthcare provider who has not contracted with a health insurance company or a Medicare Advantage plan to provide medical services to its enrolled patients. This means that the provider has not agreed to accept a set rate for their services, and the insurance company or Medicare Advantage plan may not cover the full cost of those services.

Examples of out-of-network providers include:

* Specialists: A specialist who has not contracted with a patient's insurance company may be considered out-of-network. This can result in higher costs for the patient, as the insurance company may not cover the full cost of the services provided by the specialist.
* Hospitals: A hospital that is not in a patient's network may charge higher rates for its services, and the insurance company may not cover the full cost of those services.
* Laboratories: A laboratory that is not in a patient's network may charge higher rates for its diagnostic testing services, and the insurance company may not cover the full cost of those services.
* Pharmacies: A pharmacy that is not in a patient's network may charge higher prices for prescription medications, and the insurance company may not cover the full cost of those medications.
* Home health agencies: A home health agency that is not in a patient's network may charge higher rates for its medical care and support services, and the insurance company may not cover the full cost of those services.

Using out-of-network providers can result in higher costs for patients, as the insurance company may not cover the full cost of the services provided by the provider. Patients typically have higher out-of-pocket costs when they use out-of-network providers, as opposed to providers who are in their network. Patients should always check with their insurance company to check that the provider they are going for checkup is Network Provider or Out-Of-Network Provider.

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**PCP**

PCP stands for Primary Care Physician in the US healthcare system. A primary care physician is the first point of contact for patients seeking medical care and is responsible for managing their overall health and wellness.

Examples of services provided by a primary care physician include:

* **Preventive care:** Primary care physicians provide preventive care, such as routine physical exams, screenings for conditions like cancer and heart disease, and vaccinations.
* **Diagnosis and treatment of illnesses:** Primary care physicians diagnose and treat common illnesses, such as the flu, colds, and infections. They may also manage chronic conditions, such as diabetes and hypertension.
* **Referrals to specialists:** When necessary, primary care physicians refer patients to specialists for more specialized medical care. For example, a patient with a heart condition may be referred to a cardiologist.
* **Coordination of care:** Primary care physicians are responsible for coordinating the care that a patient receives from multiple providers. They ensure that all of the patient's medical records are up-to-date and that all of the patient's providers have the information they need to provide the best possible care.
* **Patient education:** Primary care physicians educate patients about their health and wellness, helping them to make informed decisions about their care.

Having a primary care physician is important because they are the foundation of a patient's healthcare team. They provide preventive care and help to manage illnesses, and they ensure that patients receive the care they need from the right provider at the right time. Patients typically have a long-term relationship with their primary care physician, and this relationship can be a valuable source of support and guidance for patients and their families.

**POS**

POS (Point of Service) is a type of insurance plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan’s network

A POS plan blends features of an HMO with a PPO. With POS plan, you may have:

* More freedom to choose your health care providers than you would in an HMO
* A moderate amount of paperwork if you see out-of-network providers
* A primary care doctor who coordinates your care and who refers you to specialists

**What doctors you can see:** You can see in-network providers your primary care doctor refers you to. You can see out-of-network doctors, but you'll pay more.

**What you pay:**

* **Premium:** This is the cost you pay each month for insurance.
* **Deductible:** Your plan may require you to pay the amount of a deductible before it covers care beyond preventive services. You may pay a higher deductible if you see an out-of-network provider.
* **Copays or coinsurance:** You will pay either a copay, such as $15, when you get care or coinsurance, which is a percent of the charges for care. Copayments and coinsurance are higher when you use an out-of-network doctor.

**Paperwork involved:** If you go out-of-network, you have to pay your medical bill. Then you submit a claim to your POS plan to pay you back.

**KEY TAKEAWAYS**

* Point-of-service (POS) plans usually offer lower costs, but their list of providers may be limited.
* POS plans are similar to health maintenance organization (HMO), but POS plans allow customers to see out-of-network providers.
* A POS policyholder is responsible for filling all the paperwork when they visit an out-of-provider,

**How a POS Works?**

A POS plan is similar to an HMO. It requires the policyholder to choose an in-network primary care doctor and obtain referrals from that doctor if they want the policy to cover a specialist’s services. And a POS plan is like a PPO in that it still provides coverage for out-of-network services, but the policyholder will have to pay more than if they used in-network services.

However, the POS plan will pay more toward an out-of-network service if the primary care physician makes a referral than if the policyholder goes outside the network without a referral. The premiums for a POS plan fall between the lower premiums offered by an HMO and the higher premiums of a PPO.

POS plans require the policyholder to make co-payments, but in-network co-payments are often just $10 to $25 per appointment. POS plans also do not have deductibles for in-network services, which is a significant advantage over PPOs.

POS plans offer nationwide coverage, which benefits patients who travel frequently. A disadvantage is that out-of-network deductibles tend to be high for POS plans. When a deductible is high, it means that patients who use out-of-network services will pay the full cost of care until they reach the plan’s deductible. A patient who never uses a POS plan’s out-of-network services probably would be better off with an HMO because of its lower premiums.

**Disadvantage of POS Plans**

Though POS plans combine the best features of HMOs and PPOs, they hold a relatively small market share. One reason may be that POS plans are marketed less aggressively than other plans. Pricing also might be an issue. Though POS plans can be up to 50% cheaper than PPO plans, premiums can cost as much as 50% more than for HMO premiums.

While POS plans are cheaper than PPO plans, plan details can be challenging, the policies can be confusing, and many consumers don’t understand how the associated costs work. Read the plan documents especially carefully—and compare them to other choices—before deciding whether this is the best option.

**DME**

DME stands for Durable Medical Equipment in the US healthcare system. Durable medical equipment refers to medical devices that are designed to withstand repeated use and are used to help individuals with a variety of medical conditions.

Examples of durable medical equipment include:

* **Wheelchairs:** Durable wheelchairs are used by individuals with mobility impairments to help them get around.
* **Oxygen equipment:** Oxygen equipment, such as oxygen tanks and concentrators, are used by individuals with respiratory conditions to help them breathe.
* **Hospital beds:** Hospital beds are used by individuals who are recovering from an illness or injury and need to stay in bed for an extended period of time.
* **Walkers:** Walkers are used by individuals with mobility impairments to help them get around.
* **Prosthetic devices:** Prosthetic devices, such as artificial limbs, are used by individuals who have lost a limb to help them walk and perform other activities of daily living.
* **Patient lifts:** Patient lifts are used by individuals with mobility impairments to help them get in and out of bed, or to help them transfer from a wheelchair to a bed or vice versa.

Durable medical equipment is typically covered by Medicare, Medicaid, and most private health insurance plans. However, coverage can vary depending on the type of equipment and the individual's insurance plan. Patients should check with their insurance company to determine what their coverage is for durable medical equipment before they purchase or rent any equipment. In some cases, patients may be required to obtain a prescription from their physician before they can receive coverage for durable medical equipment.

**Referral**

Referral in the US healthcare system refers to the process of referring a patient from one healthcare provider to another healthcare provider for further evaluation, treatment, or medical care. A referral may be required when a patient requires medical care beyond the scope of practice of the original healthcare provider, or when a patient requires specialized care that the original healthcare provider is unable to provide.

For example, a patient with a suspected heart condition may be referred by their primary care physician to a cardiologist for further evaluation and treatment. The cardiologist will then diagnose and treat the patient and provide feedback to the primary care physician about the patient's progress.

Electronic Data Interchange (EDI) is the electronic exchange of business documents between two or more organizations. In the context of healthcare, EDI refers to the electronic exchange of healthcare data between healthcare providers, insurance companies, and other stakeholders in the healthcare system. In the case of referrals, EDI enables healthcare providers to exchange referral information electronically, which streamlines the referral process and helps ensure that the patient receives the care they need in a timely and efficient manner.

The most common EDI used in the US healthcare system for referrals is the Health Insurance Portability and Accountability Act (HIPAA) EDI standard. This standard defines the data elements, data structure, and transaction sets needed to support electronic transactions in healthcare, including referrals. The use of HIPAA EDI enables healthcare providers to exchange referral information securely and accurately, which helps to ensure that the patient receives the right care at the right time.

**Pre-Authorization**

Pre-Authorization also called precertification refers to a requirement by health plans for patients to obtain approval of a health care service or medication before the care is provided. This allows the plan to evaluate whether care is medically necessary and otherwise covered.

You can also say it like that the pre-authorization is a restriction placed in certain medications, tests, or health services by your insurance company that requires your doctor to first check and be granted permission before your plan will cover the item.

For example, imagine that you have a plan with a health insurance company and need a CT scan for a medical condition. Before the CT scan can be performed, the insurance company will need to review and approve the request for the scan. This process is known as pre-authorization. The insurance company will typically ask your healthcare provider for information about your medical condition, the reason for the scan, and the medical necessity of the procedure.

Once the insurance company has reviewed this information, they will decide on whether the CT scan will be covered under your insurance plan. If the scan is approved, the insurance company will typically provide a pre-authorization number that the healthcare provider will need to use when billing for the procedure. If the scan is not approved, the insurance company will explain why the procedure is not covered, and you may need to discuss alternative options with your healthcare provider.

It's important to note that pre-authorization is different from pre-certification, which is a similar process in which an insurance company verifies that a medical service is covered under an individual's insurance plan before the service is provided.

In conclusion, pre-authorization is a key part of the US health care system that helps to ensure that medical services and procedures are covered under an individual's insurance plan and are medically necessary.

**Q. Why is it called Pre-Authorization?**

Patients may even wait days, week or months for a necessary test or medical procedure to be scheduled because physicians need to first obtain similar authorization from an insurer. This tactic, used by insurance company to control costs, is called Pre-Authorization or Prior Authorization.

**Q. What’s the difference between Pre-Authorization and Referral Authorization?**

* **Pre-Authorization:** A system where a provider must receive approval from a staff member of the health plan, such as the health plan medical director, before a member can receive certain health care services.
* **Referral Authorization:** A formal process that authorizes an HMO member to get care from a specialist or hospital. Most HMOs require patient to get a referral from their Primary Care Doctor before seeing a specialist.

**Revenue Code**

Revenue codes are codes used in the US healthcare system to identify and classify different types of services provided to patients in a hospital setting. They are used to categorize the services provided and are essential in the billing process. The use of revenue codes is regulated by the Centers for Medicare and Medicaid Services (CMS), which is a federal agency responsible for the administration of the Medicare and Medicaid programs.

Revenue codes are used to categorize various services such as room and board charges, nursing services, diagnostic procedures, and therapeutic procedures, among others. The codes are used by healthcare providers to bill insurance companies, Medicare, and Medicaid for the services provided to patients.

For example, revenue code 024x is used to describe services related to inpatient hospital stays. These services can include room and board, nursing services, diagnostic procedures, and therapeutic procedures. Revenue code 039x is used to describe services related to rehabilitation services, such as physical therapy or occupational therapy. Revenue code 096x is used to describe services related to laboratory services, such as blood tests or urine tests.

In conclusion, revenue codes play a crucial role in the US healthcare system by allowing healthcare providers to classify and bill for the services they provide to patients. The use of these codes is regulated by CMS and is essential in the billing process to ensure that patients receive the appropriate care and that healthcare providers are fairly compensated for their services.

**RVU**

RVU, or Relative Value Unit, is a system used to determine the value of a medical service or procedure in the US healthcare system. It's a measure of the resources required to provide a specific service, including the time, skill, and equipment involved. RVUs are used by Medicare and private insurance companies to determine how much to pay healthcare providers for their services.

RVUs are calculated based on three components: the physician work involved in performing the service, the cost of the equipment and supplies used, and the overhead expenses associated with the service. The RVUs for each service are then assigned a dollar value, which is used to determine the reimbursement the provider will receive from the insurance company or Medicare.

For example, consider a service such as an office visit. The RVU for an office visit would consider the time the physician spends with the patient, the cost of any equipment used (such as a stethoscope), and the overhead expenses associated with running an office (such as rent, utilities, and administrative staff). The RVU for this service might be 2.0, meaning it takes twice as much resources as a basic service with an RVU of 1.0. Based on the RVU, the insurance company or Medicare would determine a dollar amount to reimburse the provider for the office visit.

It's important to note that RVUs are just one factor used to determine reimbursement. Other factors, such as geographical location, can also impact the payment amount. Nevertheless, RVUs play a significant role in the US healthcare system, as they provide a standardized way of determining the value of a medical service and help ensure that providers are reimbursed fairly for the resources they use to provide care.

**Self-Pay**

Self-pay refers to a situation in which an individual pay for their own healthcare expenses without the assistance of insurance. In the United States, there are many instances where individuals opt for self-pay, including:

* **Uninsured individuals:** Some individuals may choose not to have health insurance or may not be eligible for it. In such cases, they would have to pay for their medical expenses out of their own pocket.
* **Elective procedures:** Some procedures, such as cosmetic surgeries, are often not covered by insurance. In such cases, individuals would have to pay for the procedure themselves.
* **High deductibles or copays:** In some instances, individuals may have insurance plans with high deductibles or copays. In these cases, they may choose to pay for certain procedures themselves in order to avoid paying high out-of-pocket costs.
* **Concierge medicine:** Some individuals may choose to pay a flat fee to a doctor or clinic in order to receive a higher level of personalized care.

Examples of real-life situations where individuals may opt for self-pay in the US include:

* An individual may choose to pay for a cosmetic procedure, such as liposuction, themselves instead of going through insurance.
* A person who has high deductible insurance may choose to pay for a routine physical exam out of pocket, rather than pay the high deductible required by their insurance.
* An uninsured individual may choose to pay for a necessary medical procedure, such as an appendectomy, out of their own pocket.

It's worth noting that self-pay can be a cost-effective option for some individuals, as it often results in lower prices for medical services. However, it can also be financially challenging, as medical expenses can quickly become unaffordable without insurance coverage.

**Primary Insurance**

Primary insurance in the United States health care system refers to the first insurance policy that an individual use to pay for their medical expenses. The primary insurance policy is the insurance policy that pays claims first and is responsible for paying the majority of the medical bills.

For example, consider a person who has both a private insurance policy and Medicare coverage. In this case, the private insurance policy would be considered the primary insurance and Medicare would be considered the secondary insurance. The private insurance policy would pay for the majority of the medical expenses and Medicare would pay for any remaining expenses not covered by the primary insurance policy.

It's important to note that not all individuals have multiple insurance policies. Some individuals may only have one insurance policy, in which case that policy would be considered the primary insurance.

Having a primary insurance policy is important because it helps to ensure that medical expenses are covered. Without a primary insurance policy, an individual would have to pay all of their medical expenses out of their own pocket, which can quickly become unaffordable.

Additionally, having a primary insurance policy helps to ensure that medical providers receive payment for the services they provide. Without a primary insurance policy, medical providers may be less likely to provide medical services or may require payment upfront.

**Secondary Insurance**

Secondary insurance in the United States healthcare system refers to a second insurance policy that an individual has in addition to their primary insurance policy. The secondary insurance policy is designed to provide additional coverage and help to pay for expenses that the primary insurance policy may not cover.

Secondary health insurance is coverage you can buy separately from a medical plan. It helps cover you pay for care and services that your primary medical plan may not. This secondary insurance could be a vision plan, dental plan, or an accidental injury plan. Typically, secondary insurance is billed when your primary insurance plan is exhausted and may help cover additional health care costs.

For example, consider an individual who has both a private insurance policy and Medicare coverage. In this case, the private insurance policy would be considered the primary insurance and Medicare would be considered the secondary insurance. If the private insurance policy does not cover a particular medical expense, the secondary insurance policy (Medicare) would step in and cover the remaining expenses.

It's important to note that not all individuals have secondary insurance. Some individuals may only have one insurance policy, in which case that policy would be considered the primary and only insurance.

Having secondary insurance can provide peace of mind to individuals by ensuring that medical expenses are covered to the greatest extent possible. Additionally, secondary insurance can help to lower out-of-pocket costs and reduce financial burden.

Examples of secondary insurance include:

* Medicare as a secondary insurance to a private insurance policy for individuals who are eligible for both.
* Supplemental insurance, such as gap insurance or critical illness insurance, which provides coverage for specific types of medical expenses not covered by the primary insurance policy.
* An insurance policy provided by an individual's employer in addition to the individual's own insurance policy.

In conclusion, secondary insurance can provide additional financial protection and help individuals to pay for medical expenses not covered by their primary insurance policy.

**Tertiary Insurance**

Tertiary insurance in the United States healthcare system refers to a third insurance policy that an individual has in addition to their primary and secondary insurance policies. Tertiary insurance is designed to provide additional coverage and help to pay for expenses that the primary and secondary insurance policies may not cover.

Tertiary insurance is relatively rare, and most individuals only have one or two insurance policies. However, there are instances where individuals may opt to purchase a tertiary insurance policy to provide additional financial protection.

For example, consider an individual who has a private insurance policy as their primary insurance and Medicare as their secondary insurance. The individual may opt to purchase a supplemental insurance policy to provide additional coverage for expenses not covered by their primary and secondary insurance policies.

Examples of tertiary insurance include:

* Supplemental insurance, such as gap insurance or critical illness insurance, which provides coverage for specific types of medical expenses not covered by the primary or secondary insurance policies.
* Long-term care insurance, which provides coverage for expenses related to long-term care, such as nursing home stays or home health care.

In conclusion, tertiary insurance is a third insurance policy that an individual can have in addition to their primary and secondary insurance policies. Tertiary insurance is designed to provide additional coverage and help to pay for expenses not covered by the primary and secondary insurance policies. However, it is relatively rare, and most individuals only have one or two insurance policies.

**Q. Is Medicare always the primary insurance?**

If the employer has 20 or more employees, then the group health plan pays first and Medicare pays second. If the employer has fewer than 20 employees and isn’t part of a multi-employer or multiple employer group health plan, then Medicare pays first, and the group health plan pays second.  
**Q. Relate Primary, Secondary and Tertiary Insurance?**

Primary, secondary, and tertiary insurance in the United States health care system refers to a hierarchy of insurance policies that an individual has to help pay for medical expenses. Each type of insurance policy serves a different purpose and provides different levels of coverage.

* **Primary insurance** is the first insurance policy that an individual use to pay for their medical expenses. This policy is responsible for paying the majority of the medical bills and is used to cover the costs of routine medical care and hospitalization. Examples of primary insurance include private insurance policies, employer-sponsored insurance policies, and individual health insurance policies.
* **Secondary insurance** is a second insurance policy that an individual has in addition to their primary insurance policy. This policy is designed to provide additional coverage and help to pay for expenses that the primary insurance policy may not cover. Examples of secondary insurance include Medicare and supplemental insurance policies.
* **Tertiary insurance** is a third insurance policy that an individual has in addition to their primary and secondary insurance policies. Tertiary insurance is designed to provide additional coverage and help to pay for expenses not covered by the primary and secondary insurance policies. Examples of tertiary insurance include supplemental insurance policies and long-term care insurance.

In conclusion, primary, secondary, and tertiary insurance are different types of insurance policies that individuals can have to help pay for medical expenses. Each type of insurance policy serves a different purpose and provides different levels of coverage, and individuals may have one, two, or all three types of insurance policies depending on their individual needs and financial situation

**Q. What is the primary goal of tertiary care?**

Tertiary care is another form of specialized care that is a level above secondary case in that it involves supporting patients who are encountering life threatening illnesses and whose vitals are not stabilized.

**Q. What are the benefits of having secondary insurance?**

A secondary insurance policy is a plan that you get on top of your main health insurance. Secondary insurance can help you improve your coverage by giving you access to additional medical providers, such as out-of-network doctors. It can also provide benefits for uncovered health services, such as vision or dental.