Internal- RCM Industry Terms Defined

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Here are a few common acronyms that you might come across and their definitions:

- **EOB**- An explanation of benefits is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. The EOB is commonly attached to a check or statement of electronic payment.
    - These would need to be manually posted by the provider's office, or if they are on Apollo Plus, uploaded to the box.com folder for our billing team to post for them.
    - They are found under Billing > Remittance Reports if uploaded into the account.

- **ERA (835 file)**- Electronic Remittance Advice. It is a digital version of the EOB, this document describes how much of a claim the insurance company will pay, and, in the case of a denied claim, it explains why the claim was returned.
    - The payer releases these files filters them back through the clearinghouse and ends up under Billing > Remittance Reports.
    - They are posted to patient appointments as soon as they are received into the system unless the "needs verification" setting is enabled.
    - Any payment that cannot be matched to an appointment will be posted under Billing > Unmatched ERAs. These could be appointments where the charges have changed since the appointment was billed, or billed out of a different system.
    - Often referred to as an 835 file.

- **Billing Picklist**- Commonly used ICD-10 and procedure codes used in the client's billing. They can create these "favorites" lists for codes they use often to increase their efficiency in finding them.

- **Super Bill**- is an itemized form reflecting rendered services. It is used primarily by patients who are seeing an out-of-network provider to submit to their payer (insurance, funds, programs) for reimbursement.
    - Providers who are out-of-network for a patient's insurance typically do not submit claims for their patients. They will collect funds upfront and give the patient a Superbill to submit to their payer to recoup payment themselves.

- **Fee for Service**- this is a payment model where services are unbundled and paid for separately. In health care, it gives an incentive for physicians to provide more treatments because payment is dependent on the quantity of care, rather than the quality of care. Payments are issued per service rendered.

- **Value-Based Care**-Value-based care is a form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness. It aims to advance the triple aim of providing better care for individuals, improving population health management strategies, and reducing health care costs. Its focus is on patient outcomes and how well healthcare providers can improve the quality of care based on specific measures, such as reducing hospital readmissions, using certified health IT, and improving preventative care.

- **EPCS**-Acronym stands for Electronic Prescriptions for Controlled Substances. The EPCS feature in DrChrono provides practitioners with the option of writing and transmitting prescriptions for controlled substances electronically, instead of handing their patients a paper prescription that can be lost.

- **Fee Schedule**- A fee schedule is a complete listing of fees charged by providers for their services. Many providers base their fees on a % of Medicare reimbursements.
    - It is advisable that a practice charge an amount that is OVER what they are expecting to be reimbursed by the payer. The reason is, that the payer has a maximum amount they will reimburse for each CPT/HCPCS, but it is the lower of either their maximum amount or the amount the provider billed. If the payer allows $100 for a certain code and the provider only billed $75, they will only be reimbursed $75. They could have had the additional $25 if they had only billed higher.

- **Revenue Cycle Management**- The process from beginning to end, of translating the work performed by the doctor and their staff into payment. The cycle begins with the appointment and ends with the final payment from the carrier and/or patient that satisfies all charges.

- **Clearinghouse**-In medical billing, companies that function as intermediaries who forward claims information from healthcare providers to insurance payers are known as clearinghouses. In what is called claims scrubbing, clearinghouses check the claim for errors and verify that it is compatible with the payer software.
    - Current DrChrono Clearinghouses - ePS, TriZetto, Change Healthcare (fka Emdeon),eProvider Solutions (ePS), and Carisk Partners fka iHCFA (for work comp/auto accident)
    - Claim files are often referred to as 837 file

- **Medicaid**- The federal program created by the 1965 Social Security Act that helps low-income people pay for their medical bills. The U.S. Department of Health and Human Services regulates the Medicaid program, but each state is responsible for its own program administration. These programs are completely voluntary, but each state has some form of Medicaid program available to eligible residents.

- **Medicare**- The federal health insurance program for people 65 years or older, under age 65 with certain disabilities, and any age with end-stand renal disease or Lou Gehrig's disease. Medicare has four parts; Part A (inpatient hospital insurance), Part B (outpatient medical insurance), Part C (known as Medicare Advantage Plans), and Part D (prescription drug coverage).

- **Medicare Advantage Plan** - This is a plan where the Medicare-eligible patient gives up their regular government Medicare in lieu of a commercial payer's Medicare plan. As of this writing, companies such as United Healthcare, Humana, and some Blue Cross plans all offer a Medicare Advantage Plan. Instead of having government part A/B coverage and a supplement, patients on these plans are covered by the commercial payer only. Many patients believe these plans are in addition to their government Medicare; they are not, they are a replacement. The advertising for these plans doesn't make that clear and gains interest from patients by including coverage for prescription drugs, and vision and dental coverage (which regular Medicare patients have to pay separately for).

- **Meaningful Use**-Meaningful use (MU), in a health information technology (HIT) context, defines minimum U.S. government standards for using electronic health records (EHR) and for exchanging patient clinical data between healthcare providers, between healthcare providers and insurers, and between healthcare providers and patients. MU sets specific objectives that eligible professionals (EPs) and hospitals must achieve to qualify for Centers for Medicare & Medicaid Services (CMS) Incentive Programs.

- **HIPAA**-Acronym stands for the Health Insurance Portability and Accountability Act, a U.S. law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers.

- **ICD- 9 Codes**- The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is the U.S. health system's adaptation of the international ICD-9 standard list of six-character alphanumeric codes to describe diagnoses.
    - They ceased being used on September 30, 2015; the use of ICD-10 codes began on October 1, 2015.

- **ICD-10 Codes**- The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care in the United States.
    - Became effective on October 1, 2015.

- **NDC Codes**-The NDC, or National Drug Code, is a unique 10-digit, 3-segment number. It is a universal product identifier for human drugs in the United States. The code is present on all nonprescription (OTC) and prescription medication packages and inserts in the US.
    - NDCs are required on medical claims to disclose which medication, which manufacturer, and what dosage was given to a patient. The number can be found on the side of the package/bottle. NDCs are on each individual vial of medication, as well as the box for a multi-vial lot. **Providers who purchase a multi-vial lot should bill with the NDC that is on the outside of the box, not the one on the vial.** Providers who purchase a single vial should bill the NDC on the vial.

- **CPT Codes**-Current Procedural Terminology (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations.

- **HCPCS Codes**- Healthcare Common Procedure Coding System (HCPCS), commonly pronounced: "hick-pick." These codes represent non-physician services like ambulance rides, wheelchairs, walkers, other durable medical equipment, and other medical services that don't fit readily into Level I. Where CPT describes the procedure performed on the patient, it doesn't have many codes for the product used in the procedure. HCPCS Level II takes care of those products and pieces of medical equipment.

- **Custom Codes**- non-billable codes to insurance, but billed to the patient. Often used for inventory items such as vitamins, supplements, preparation of FMLA/disability forms, no-show appointments, etc.

- **MACRA**- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan federal legislation signed into law by President Obama on April 16, 2015. The law does many things, but most importantly it establishes a new payment framework that rewards healthcare providers for giving better care instead of more service. The law also includes new funding for technical assistance to providers, and funding for measure development and testing, it enables new programs and requirements for data sharing and establishes new federal advisory groups.

- **MIPS**- The Merit-based Incentive Payment System (MIPS) is the name of a new program, established in January 2017. This program combines MACRA, part of the Physician Quality Reporting System (PQRS), Value-based modifier (VBM), and the Medicare Electronic Health Record (EHR) incentive program to create the program called MIPS. It determines Medicare payment adjustments and uses a composite performance score that eligible professionals (EPs) may receive a payment bonus, a payment penalty, or no payment adjustment.