Medical Billing Glossary

Below is a complete list of terminology for all medical billers and coders.

5010 - Version 5010 of the X12 HIPAA transaction and code set standards for electronic healthcare transactions. This standard includes transactions for claims, referrals, claim status, eligibility, and remittances. Mandatory compliance date was January 1, 2012. These standards are necessary for the new ICD-10-CM diagnosis codes.

ACA - Affordable Care Act. Also referred to as "ObamaCare". A Federal law enacted in 2010 intended to increase healthcare coverage and make it more affordable. It also expands Medicaid eligibility and guarantees coverage without regard to pre-existing medical conditions.

Accept Assignment - When a healthcare provider accepts as full payment the amount paid on a claim by the insurance company. This excludes patient responsible amounts such as coinsurance or co-pay.

Adjusted Claim - When a claim is corrected which results in a credit or payment to the provider.

Allowed Amount - The reimbursement amount an insurance company will pay for a healthcare procedure. This amount varies depending on the patient's insurance plan. For 80/20 insurance, the provider accepts 80% of the allowed amount and the patient pays the remaining 20%.

AMA - American Medical Association. The AMA is the largest association of doctors in the United States. They publish the Journal of American Medical Association which is one of the most widely circulated medical journals in the world.

Aging – is referred to the unpaid insurance claims or patient balances that are due past 30 days. Most medical billing software's have the ability to generate a separate report for insurance aging and patient aging. These reports typically list balances by 30, 60, 90, and 120 day increments.

Ancillary Services - These are typically services a patient requires in a hospital setting that are in addition to room and board accommodations –Examples: surgery, lab tests, counseling, therapy, etc.

Appeal - When an insurance plan does not pay for treatment, an appeal (either by the provider or patient) is the process of objecting this decision. The insurer may require documentation when processing an appeal and typically has a formal policy or process established for submitting an appeal. Many times the process and associated forms can be found on the insurance provider's web site.

Applied to Deductible (ATD) – This is usually found on the patient statement. This is the amount of the charges, determined by the patients insurance plan, the patient **owes** the provider. Many plans have a maximum annual deductible that once met is then covered by the insurance provider.

Assignment of Benefits (AOB) - Insurance payments that are paid directly to the doctor or hospital for a patients treatment. This is designated in Box 27 of the CMS-1500 claim form.

ASP – (Application Service Provider) –It is a way for companies to outsource some or all aspects of their information technology needs. It frees a business of the need to purchase, maintain, and backup software and servers.

Authorization - When a patient requires permission (or authorization) from the insurance company before receiving certain treatments or services.

Beneficiary - Person or persons covered by the health insurance plan and eligible to receive benefits.

Blue Cross Blue Shield (BCBS) - An organization of affiliated insurance companies (approximately 450), independent of the association (and each other), that offer insurance plans within local regions under one or both of the association's brands (Blue Cross or Blue Shield). Many local BCBS associations are non-profit BCBS sometimes acts as administrators of Medicare in many states or regions.

Capitation - A fixed payment paid per patient enrolled over a defined period of time that is paid to a health plan or provider. This covers the costs associated with the patient's health care services. This payment is not affected by the type or number of services provided.

Carrier - The insurance company or "carrier" the patient has a contract with to provide health insurance.

Category I Codes - Codes for medical procedures or services identified by the 5 digit CPT Code.

Category II Codes - Optional performance measurement tracking codes which are numeric with a letter as the last digit (example: 9763B).

Category III Codes - Temporary codes assigned for collecting data which are numeric followed by a letter in the last digit (example: 5467U).

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)-Recently renamed TRICARE. This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors.

Charity Care - When medical care is provided at no cost or at reduced cost to a patient that cannot afford to pay.

Clean Claim - A complete submitted insurance claim that has all the necessary correct information without any omissions or mistakes that allows it to be processed and paid promptly.

Clearinghouse - This is a service that transmits claims to insurance carriers. Prior to submitting claims the clearinghouse scrubs claims and checks for errors. This minimizes the amount of rejected claims as most errors can be easily corrected. Clearinghouses electronically transmit claim information that is compliant with the strict HIPPA standards (this is one of the medical billing terms we see a lot more of lately).

CMS (Centers for Medicaid and Medicare Services)- Federal agency which administers Medicare, Medicaid, HIPPA, and other health programs. Formerly known as the HCFA (Health Care Financing Administration). You'll notice that CMS is the source of a lot of medical billing terms.

CMS 1500- Medical claim form established by CMS to submit paper claims to Medicare and Medicaid. Most commercial insurance carriers also require paper claims be submitted on CMS-1500's. The form is distinguished by its red ink.

Coding - Medical Billing Coding involves taking the doctors notes from a patient visit and translating them into the proper diagnosis (ICD-9 or ICD-10 code) and treatment, such as CPT codes. This is for the purpose of reimbursing the provider and classifying diseases and treatments.

COBRA Insurance - This is health insurance coverage available to an individual and their dependents after becoming unemployed - either voluntary or involuntary termination of employment for reasons other than gross misconduct. Because it does not typically receive company matching, It's typically more expensive than insurance the cost when employed but does benefit from the savings of being part of a group plan. Employers must extend COBRA coverage to employees dismissed for a. COBRA stands for Consolidated Omnibus Budget Reconciliation Act which was passed by Congress in 1986.

COBRA coverage typically lasts up to 18 months after becoming unemployed and under certain conditions extends up to 36 months.

Co-Insurance - Percentage or amount defined in the insurance plan for which the patient is responsible. Most plans have a ratio of 90/10 or 80/20, 70/30, etc. For example the insurance carrier pays 80% and the patient pays 20%.

Collection Ratio - This is in reference to the provider's accounts receivable. It's the ratio of the payments received to the total amount of money owed on the provider's accounts. For example, they have received 90% of a payment, and the remaining balance is 10% that still has to be paid.

Contractual Adjustment - The amount of charges a provider or hospital agrees to write off and not charge the patient per the contract terms with the insurance company.

Coordination of Benefits (COB) - When a patient is covered by more than one insurance plan. One insurance carrier is designated as the primary carrier and the other as secondary.

Co-Pay - Amount paid by patient at each visit as defined by the insured plan.

CPT Code (Current Procedural Terminolog)- This is a 5 digit code assigned for reporting a procedure performed by the physician. The CPT has a corresponding ICD-9 diagnosis code. It was established by the American Medical Association. (**COMMON MEDICAL BILLING TERM).**

Credentialing - This is an application process for a provider to participate with an insurance carrier. Many carriers now request credentialing through CAQH. The CAQH credentialing is a universal system now accepted by insurance company networks.

Credit Balance - The balance that's shown in the "Balance" or "Amount Due" column of your account statement with a minus sign after the amount (for example $50-). It may also be shown in parenthesis; ($50). The provider may owe the patient a refund.

Crossover claim - When claim information is automatically sent from Medicare the secondary insurance such as Medicaid.

Date of Service (DOS) - Date that health care services were provided.

Day Sheet - Summary of daily patient treatments, charges, and payments received.

Deductible - Amount patient must pay before insurance coverage begins. For example, a patient could have a $1000 deductible per year before their health insurance will begin paying. This could take several doctor's visits or prescriptions to reach the deductible.

Demographics - Physical characteristics of a patient such as age, sex, address, etc. necessary for filing a claim.

DME - Durable Medical Equipment - Medical supplies such as wheelchairs, oxygen, catheter, glucose monitors, crutches, walkers, etc.

DOB - Abbreviation for Date of Birth

Downcoding - When the insurance company reduces the code (and corresponding amount) of a claim when there is no documentation to support the level of service submitted by the provider. The insurer's computer processing system converts the code submitted down to the closest code in use which usually reduces the payment.

Duplicate Coverage Inquiry (DCI) - Request by an insurance company or group medical plan by another insurance company or medical plan to determine if other coverage exists.

Dx - Abbreviation for diagnosis code (ICD-9 or ICD-10 code).

Electronic Claim - Claim information is sent electronically from the billing software to the clearinghouse or directly to the insurance carrier. The claim file must be in a standard electronic format as defined by the receiver.

Electronic Funds Transfer (EFT) - An electronic paperless means of transferring money. This allows funds to be transferred, credited, or debited to a bank account and eliminates the need for paper checks.

E/M – The Evaluation and Management section of the CPT codes. These are the CPT codes 99201 thru 99499 most used by physicians to access (or evaluate) a patient's treatment needs.

EMR - Electronic Medical Records. Also referred to as EHR (Electronic Health Records). This is a medical record in digital format of a patient's hospital or provider treatment. An EMR is the patient's medical record managed at the provider's location. The EHR is a comprehensive collection of the patients medical records created and stored at several locations.

Encryption – The conversion of data into a form that cannot be easily seen by someone who is not authorized. Encrypted e-mails may be used when sending patient info to comply with HIPAA requirements for protection of patient information.

Enrollee - Individual covered by health insurance.

EOB –(Explanation of Benefits) The statement that comes with the insurance company payment to the provider explaining payment details, covered charges, write offs, and patient responsibilities and deductibles.

ERA (Electronic Remittance Advice)- This is an electronic version of an insurance EOB that provides details of insurance claim payments. These are formatted in according to the HIPAA X12N 835 standard.

ERISA (Employee Retirement Income Security Act of 1974)- This law established the reporting, disclosure of grievances, and appeals requirements and financial standards for group life and health. Self-insured plans are regulated by this law.

Errors and Omissions Insurance - Liability insurance for professionals to cover mistakes which may cause financial harm to another part.

Fair Credit Reporting Act - Federal law that regulates the collection and use of consumer credit information.

Fair Debt Collection Practices Act (FDCPA) - Federal law that regulates creditor or collection agency practices when trying to collect on past due accounts.

Fee For Service - Insurance where the provider is paid for each service or procedure provided. Typically allows patient to choose provider and hospital. Some policies require the patient to pay provider directly for services and submit a claim to the carrier for reimbursement. The trade-off for this flexibility is usually higher deductibles and co-pays.

Fee Schedule - Cost associated with each CPT treatment billing code for a provider's treatment or services.

Financial Responsibility - The portion of the charges that are the responsibility of the patient or insured.

Fiscal Intermediary (FI) - A Medicare representative who processes Medicare claims.

Formulary - A list of prescription drug costs which an insurance company will provide reimbursement for.

Fraud - When a provider receives payment or a patient obtains services by deliberate, dishonest, or misleading means.

GPH –(Group Health Plan)-A means for one or more employer who provide health benefits or medical care for their employees (or former employees).

Group Name - Name of the group or insurance plan that insures the patient.

Group Number - Number assigned by insurance company to identify the group under which a patient is insured.

Guarantor - A responsible party and/or insured party who is not a patient.

HCFA (Health Care Financing Administration.)-Now known as CMS (see above in Medical Billing Terms).

HCPCS (Health Care Financing Administration Common Procedure Coding System) (pronounced "hick-picks") A standardized medical coding system used to describe specific items or services provided when delivering health services. It may also be referred to as a procedure code in the medical billing glossary.

The three HCPCS levels are:

- Level I - American Medical Associations Current Procedural Terminology (CPT) codes.
- Level II - The alphanumeric codes which include mostly non-physician items or services such as medical supplies, ambulatory services, prosthesis, etc. These are items and services not covered by CPT (Level I) procedures.
- Level III - Local codes used by state Medicaid organizations, Medicare contractors, and private insurers for specific areas or programs.

Health Savings Account - Also known as, **Flexible Spending Account.** A tax exempt account provided by an employer from which an employee can pay health care related expenses. The current limit is $2500 per year.

Healthcare Insurance - Insurance coverage to cover the cost of medical care necessary as a result of illness or injury. It can be an individual policy or family policy which covers the beneficiary's family members. It also may include coverage for disability or accidental death or dismemberment.

Healthcare Provider - Typically a physician, hospital, nursing facility, or laboratory that provides medical care services. It should not be confused with insurance providers or the organization that provides insurance coverage.

Health Care Reform Act - Health care legislation championed by President Obama in 2010 to provide improved individual health care insurance or national health care insurance for Americans. It is also referred to as the Health Care Reform Bill or the Obama Health Care Plan.

HIC (Health Insurance Claim)- This is a number assigned by the Social Security Administration to a person to identify them as a Medicare beneficiary. This unique number is used when processing Medicare claims.

HIPAA(Health Insurance Portability and Accountability Act)- There are several federal regulations intended to improve the efficiency and effectiveness of health care and establish privacy and security laws for medical records.

HMO (Health Maintenance Organization) A type of health care plan that places restrictions on treatments.

Hospice - Inpatient, outpatient, or home healthcare for terminally ill patients.

ICD-9 Code - Also known as ICD-9-CM-It is the International Classification of Diseases classification system used to assign codes to patient diagnosis. This is a 3 to 5 digit number.

ICD 10 Code The 10th revision of the International Classification of Diseases. This is a 3 to 7 digit number. It includes additional digits to allow more available codes. The U.S. Department of Health and Human Services has set an implementation deadline of October, 2013 for ICD-10.

Incremental Nursing Charge - Charges for hospital nursing services in addition to basic room and board.

Indemnity - Also referred to as fee-for-service. This is a type of commercial insurance where the patient can use any provider or hospital.

In-Network (or Participating) - An insurance plan in which a provider signs a contract to participate in. The provider agrees to accept a discounted rate for procedures.

Inpatient - Hospital stay of more than one day (24 hours).

IPA (Independent Practice Association)- An organization of physicians that are contracted with a HMO plan.

Intensive Care - Hospital care unit providing care for patients who need more than the typical general medical or surgical area of the hospital can provide. May be extremely ill or seriously injured and require closer observation and/or frequent medical attention.

MAC - Medicare Administrative Contractor.

Managed Care Plan – An insurance plan requiring a patient to see doctors and hospitals that are contracted with the managed care insurance company. Medical emergencies or urgent care are exceptions when out of the managed care plan service area.

Maximum Out of Pocket - The maximum amount the insured is responsible for paying for eligible health plan expenses. When this maximum limit is reached, the insurance typically then pays 100% of eligible expenses.

Meaningful Use - A provision of the 2009 HITECH act that provides stimulus money to providers who implement Electronic Health Records (EHR). Providers who implement EHR must show "Meaningful Use" and meet certain requirements defined in the act. The incentive is $63,750 over 6 years for Medicaid and $44,000 over 5 years for Medicare. Providers who do not implement EHR by 2015 are penalized 1% of Medicare payments increasing to 3% over 3 years.

Medical Assistant - A health care worker who performs administrative and clinical duties in support of a licensed health care provider such as a physician, physicians assistant, nurse, nurse practitioner, etc.

Medical Coder - Analyzes patient charts and assigns the appropriate code. These codes are derived from ICD-9 codes (soon to be ICD-10) and corresponding CPT treatment codes and any related CPT modifiers.

Medical Billing Specialist - Processes insurance claims for payment of services performed by a physician or other health care provider. Ensures patient medical billing codes, diagnosis, and insurance information are entered correctly and submitted to insurance payer. Enters insurance payment information and processes patient statements and payments. They Perform tasks vital to the financial operation of a practice.

Medical Necessity – A medical service or procedure that is performed for treatment of an illness or injury that is not considered investigational, cosmetic, or experimental.

Medical Record Number - A unique number assigned by the provider or health care facility to identify the patient medical record.

MSP - Medicare Secondary Payer.

Medical Savings Account - Tax exempt account for paying medical expenses administered by a third party to reimburse a patient for eligible health care expenses. Typically provided by employer where the employee contributes regularly to the account before taxes and submits claims or receipts for reimbursement. It is also known as the Medical Spending Account.

Medical Transcription- The conversion of voice recorded or hand written medical information dictated by health care professionals (such as physicians) into text format records. These records can be either electronic or paper.

Medicare - Insurance provided by federal government for people over 65 or people under 65 with certain restrictions. There are 2 parts:

- **Medicare Part A** - Hospital coverage
- **Medicare Part B** - Physicians visits and outpatient procedures
- **Medicare Part D** - Medicare insurance for prescription drug costs for anyone enrolled in Medicare Part A or B.

Medicare Coinsurance Days-Inpatient hospital coverage from day 61 to day 90 of a continuous hospitalization. The patient is responsible for paying for part of the costs during those days. After the 90th day, the patient enters "Lifetime Reserve Days."

Medicare Donut Hole - The gap or difference between the initial limits of insurance and the catastrophic Medicare Part D coverage limits for prescription drugs.

Medicaid - Insurance coverage for low income patients. Funded by Federal and state government and administered by states.

Medigap - Medicare supplemental health insurance for Medicare beneficiaries which may include payment of Medicare deductibles, co-insurance and balance bills, or other services not covered by Medicare.

Modifier - Modifier to a CPT treatment code that provides additional information to insurance payers for procedures or services that have been altered or "modified" in some way. Modifiers are important to explain additional procedures and obtain reimbursement for them.

N/C (Non-Covered Charge)- A procedure not covered by the patient's health insurance plan.

NEC (Not Elsewhere Classifiable)- It is used in ICD when information needed to code the term in a more specific category is not available.

Network Provider - Health care provider who is contracted with an insurance provider to provide care at negotiated costs.

Nonparticipation - When a healthcare provider chooses not to accept Medicare-approved payment amounts as payment in full.

NOS (Not Otherwise Specified)- Used in ICD for unspecified diagnosis.

NPI Numbe (- National Provider Identifier)- A unique 10 digit identification number required by HIPAA and assigned through the National Plan and Provider Enumeration System (NPPES).

OIG (Office of Inspector General) - Part of the department of Health and Human Services. It established compliance requirements to combat healthcare fraud and abuse. It has guidelines for billing services, and, individual and small group physician practices.

Out-of Network (or Non-Participating) - A provider that does not have a contract with the insurance carrier. Patients are usually responsible for a greater portion of the charges or may have to pay all the charges for using an out-of network provider.

Out-Of-Pocket Maximum - The maximum amount the patient has to pay under their insurance policy. Anything above this limit is the insurer's obligation. These Out-of-pocket maximums can apply to all coverage or to a specific benefit category such as prescriptions.

Outpatient - Typically treatment in a physician's office, clinic, or day surgery facility lasting less than one day.

Palmetto GBA - An administrator of Medicare health insurance for the Centers for Medicare & Medicaid Services (CMS) in the US and its territories. A wholly owned subsidiary of BlueCross BlueShield of South Carolina based in Columbia, South Carolina.

Patient Responsibility - The amount a patient is responsible for paying that is not covered by the insurance plan.

PCP (Primary Care Physician)- Usually the physician who provides initial care and coordinates additional care if necessary.

POS (Point-of-Service Plan)-A flexible type of HMO (Health Maintenance Organization) plan where patients have the freedom to use (or self-refer to) non-HMO network providers. When a non-HMO specialist is seen without referral from the Primary Care Physician (self-referral), they have to pay a higher deductible and a percentage of the coinsurance.

POS (Used on Claims) (Place of Service) This is used on medical insurance claims - such as the CMS 1500 block 24B. A two digit code which defines where the procedure was performed. For example 11 is for the doctors office, 12 is for home, 21 is for inpatient hospital, etc.

PPO (Preferred Provider Organization)- Commercial insurance plan where the patient can use any doctor or hospital within the network. (Similar to an HMO).

Practice Management Software - software used for the daily operations of a provider's office. Typically used for appointment scheduling and billing.

Preauthorization - Requirement of insurance plan for primary care doctor to notify the patient's insurance carrier of certain medical procedures (such as outpatient surgery) for those procedures to be considered a covered expense.

Pre-Certification - Sometimes required by the patient's insurance company to determine medical necessity for the services proposed or rendered. This doesn't guarantee the benefits will be paid.

Predetermination - Maximum payment insurance will pay towards surgery, consultation, or other medical care - determined before treatment.

Pre-existing Condition (PEC) - A medical condition that has been diagnosed or treated within a certain specified period of time just before the patient's effective date of coverage. A Pre-existing condition may not be covered for a determined amount of time as defined in the insurance terms of coverage (typically 6 to 12 months).

Pre-existing Condition Exclusion - When insurance coverage is denied for the insured when a pre-existing medical condition existed when the health plan coverage became effective.

Premium - The amount the insured or their employer pays (usually monthly) to the health insurance company for coverage.

Privacy Rule - The HIPAA privacy standard establishes requirements for disclosing what the HIPAA privacy law calls Protected Health Information (PHI). PHI is any information on a patient about the status of their health, treatment, or payments.

Protected Health Information (PHI) - An individuals identifying information such as name, address, birth date, Social Security Number, telephone numbers, insurance ID numbers, or information pertaining to healthcare diagnosis or treatment.

Provider - Physician or medical care facility (hospital) which provides health care services.

PTAN (Provider Transaction Access Number) -Also known as the legacy Medicare number.

Referral - When one provider (usually a family doctor) refers a patient to another provider (typically a specialist).

Remittance Advice (R/A) - A document supplied by the insurance payer with information on claims submitted for payment. It contains explanations for rejected or denied claims. It is lso referred to as an EOB (Explanation of Benefits).

Responsible Party - The person responsible for paying a patient's medical bill. Also known as the guarantor.

Revenue Code – The 3-digit number used on hospital bills to tell the insurer where the patient was when they received treatment, or what type of item a patient received.

RVU (Relative Value Amount) This is the average amount Medicare will pay a provider or hospital for a procedure (CPT-4). This amount varies depending on geographic location.

Scrubbing - Process of checking an insurance claim for errors in the health insurance claim software prior to submitting to the payer.

Self-Referral - When a patient sees a specialist without a primary physician referral.

Self Pay - Payment made at the time of service by the patient.

Secondary Insurance Claim – A claim for insurance coverage paid after the primary insurance makes payment. Secondary insurance is typically used to cover gaps in insurance coverage.

Secondary Procedure - When a second CPT procedure is performed during the same physician visit as the primary procedure.

Security Standard - Provides guidance for developing and implementing policies and procedures to guard and mitigate compromises to security. The HIPAA security standard is kind of a sub-set or compliment to the HIPAA privacy standard. Where the HIPAA policy privacy requirements apply to all patient Protected Health Information (PHI), HIPAA policy security laws apply more specifically to electronic PHI.

Skilled Nursing Facility - A nursing home or facility for convalescence. It provides a high level of specialized care for long-term or acutely ill patients. A Skilled Nursing Facility is an alternative to an extended hospital stay or home nursing care.

SOF - Signature on File.

Software As A Service (SAAS) –A software application that is hosted on a server and accessible over the Internet. SAAS relieves the user of software maintenance and support and the need to install and run an application on an individual local PC or server. Many medical billing applications are available as SAAS.

Specialist - Physician who specializes in a specific area of medicine, such as urology, cardiology, orthopedics, oncology, etc. Some healthcare plans require beneficiaries to obtain a referral from their primary care doctor before making an appointment to see a Specialist.

Subscriber – Describes the employee for group policies. For individual policies the subscriber describes the policyholder.

Superbill – The form the provider uses to document the treatment and diagnosis for a patient visit. Typically includes several commonly used ICD-9 diagnosis and CPT procedural codes. One of the most frequently used medical billing terms.

Supplemental Insurance - Additional insurance policy that covers claims fro deductibles and coinsurance. Frequently used to cover these expenses not covered by Medicare.

TAR (Treatment Authorization Request) An authorization number given by insurance companies prior to treatment in order to receive payment for services rendered.

Taxonomy Code - Specialty standard codes used to indicate a provider's specialty sometimes required to process a claim.

Term Date - Date the insurance contract expired or the date a subscriber or dependent ceases to be eligible.

Tertiary Insurance Claim - Claim for insurance coverage paid in addition to primary and secondary insurance. Tertiary insurance covers gaps in coverage the primary and secondary insurance may not cover.

Third Party Administrator (TPA) - An independent corporate entity or person (third party) who administers group benefits, claims, and administration for a self-insured company or group.

TIN (Tax Identification Number)- Also known as Employer Identification Number (EIN).

TOP (Triple Option Plan) An insurance plan which offers the enrolled a choice of a more traditional plan, an HMO, or a PPO. This is also commonly referred to as a cafeteria plan.

TOS (Type of Service.)- Description of the category of service performed.

TRICARE - This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors. Formerly known as CHAMPUS.

UB04 - Claim form for hospitals, clinics, or any provider billing for facility fees similar to CMS 1500. Replaces the UB92 form.

Unbundling - Submitting several CPT treatment codes when only one code is necessary.

Untimely Submission - Medical claim submitted after the time frame allowed by the insurance payer. Claims submitted after this date are denied.

Upcoding - An illegal practice of assigning an ICD-9 diagnosis code that does not agree with the patient records for the purpose of increasing the reimbursement from the insurance payer.

UPIN (Unique Physician Identification Number)A 6 digit physician identification number created by CMS. Discontinued in 2007 and replaced by NPI number.

Usual Customary & Reasonable(UCR) - The allowable coverage limits (fee schedule) determined by the patients insurance company to limit the maximum amount they will pay for a given service or item as defined in the contract with the patient.

Utilization Limit - The limits that Medicare sets on how many times certain services can be provided within a year. The patients claim can be denied if the services exceed this limit.

Utilization Review (UR) - Review or audit conducted to reduce unnecessary inpatient or outpatient medical services or procedures.

V-Codes - ICD-9-CM coding classification to identify health care for reasons other than injury or illness.

Workers Comp - Insurance claim that results from a work related injury or illness.

Write-off - Typically referring to the difference between what the physician charges and what the insurance plan contractually allows, and what the patient is not responsible for. May also be referred to as "not covered".