

Reimbursement Terminology

TERM NAME	DEFINITION
Accounts Receivable	Charges outstanding for services rendered to patients.
Adjusted Charges	Difference between gross charges and contractual adjustments.
Adjustments	Dollar amount written off as a result of contractual adjustments.
Aging	The process of categorizing patient account totals within certain time segments (usually 30 days) based on the time since the service was rendered.
Average Monthly Collections	Average monthly collections over the year-to-date period or prior 12-months.
Burdened Non-MD Payroll	Gross payroll, plus employee payroll taxes and benefits.
Co-Insurance	The amount the patient is responsible to pay after their insurance benefits have been processed.
Co-Pay	The term is normally used in connection with a managed care plan. This is the amount (usually \$5 or \$10) the patient is required to pay for services rendered. The HMO benefits cover the difference between the allowable charge amount and the co-payment amount.
CPT Code	Current Procedural Terminology Code - A systematic listing and coding of procedures and services performed by physicians. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physician is accurately defined.
Days Sales Outstanding	A statistical measurement of collections performance computed by dividing total accounts receivable by average daily charges. Daily charges are normally measured over an extended period, in most cases three months.
Deductible	The threshold amount that patient charges must meet before their insurance benefits apply.
Electronic Submission	Method of using a modem to transmit claims from a computer system over a telephone line to a carrier's computer system.
EOB	Explanation of Benefits. The EOB provides data needed to properly credit payment for the patient and the date of service, or explain why the claim is being denied and the payment is not being made.
Expected Collections	The amount a physician will receive from a patient or third-party payer for a service rendered. For example, the expected collection for an office visit may be \$50, whereas the gross charge was \$65.
FDCPA	Federal Debt Collection Practices Act.
Full-Time Equivalents (FTE)	The number of non-MD employees. For part-time employees, hours are calculated and then prorated to full-time status using 2,080 hours in the denominator.
Global Period	A defined period of time proximal to a surgical procedure that includes related pre- and post-operative services; payment for such services is included in the

	primary procedure payment. All services performed during this period that relate to the surgery performed are included in the surgical fee.
Gross Charges	Charges billed to patients for medical and surgical services performed, prior to contractual adjustments or discounts.
Gross Non-MD Payroll	Gross wages of all practice personnel with the exception of MDs.
HCFA 1500	A universal claim form developed by the Health Care Financing Administration that is used to bill most third-party payers.
HCPCS	HCFA Common Procedural Coding System - The system of classification of goods and services that includes CPT codes. CPT coding does not include classification for goods such as medications, supplies, and prosthetics.
HMO	Health Maintenance Organization.
ICD-9-CM Codes	International Classification of Diseases, 9th Revision, Clinical Modification - The system used to convert clinical diagnoses and presentations to a numeric code.
Medicare Allowable	Total amount the practice is allowed to collect for a service rendered to a Medicare patient. Medicare will reimburse 80% of this amount. The patient (or patient's secondary insurance) is responsible for maintaining 20%.
Medicare Assignment	A process whereby a physician accepting Medicare assignment agrees to accept the Medicare allowable fee. The difference between usual charges and Medicare allowable is written off the patient's account.
Net Collections	All monies received by the practice for medical and surgical services performed (net of patient refunds).
RBRVS	Resource-based relative value scale.
Reconciliation	The process of comparing information from independent sources to verify accuracy of information
RVU	Relative value unit.
Superbill	This comprehensive form used for billing purposes to identify, record, and track specific information such as procedures, diagnoses, charges, and payments.
Third-Party Payer	The entity that assumes responsibility for providing benefits to patients and payments to providers in exchange for receiving premiums. Such payers may include indemnity insurers, governmental entities, HMOs, and others.
UB-92	A claim form administered by HCFA used for billing services provided by ambulatory surgery centers.