Easy Insurance Lingo

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Accumulators: What has been added together for any given plan/calendar year: Deductibles, OOP Maximums, Visit Limits

Allowable Amount: This is the amount each plan will allow for any given service. This may be different than the amount you're charging.

Appeal: The process the provider (or their biller) goes through to fight a denied claim in hopes to overturn their decision and acquire payment. Documentation will be required to be submitted and reviewed.

Batching: When you group multiple claims/DOS' together before sending them to the clearinghouse.

Claims Rejections & Denials: A claim will become rejected at the scrubbing phase should there be incorrect/incomplete information. A claim will become denied when the Payor processed the claim and found no coverage/exceeded limits/no prior authorization, etc.

Clearinghouses: The system the provider uses as the "middleman" to push the claim to the proper insurance plans.

Co-Insurance: The percentage of a claim the patient is responsible for after meeting their deductible. Ex: A patient's 20% co-insurance would require them to pay $20 of an allowed $100 charge.

Coordination of Benefits (COB): When a patient has more than one plan, they need to coordinate those benefits so the plans know about one another and decide in which order they will be paying. Needs to be done by patient.

Co-Pay: The patient has a set fee for a specific provider. Ex: $10 Co-Pay to see a Primary Care doctor.

CPT Code: The code associated with the services you're performing

Credentialing: The act of becoming INN with a Payor.

Deductible: The amount a patient must hit before their insurance will cover any portion of any charges.

DX Code: The code that represents the ailment/issue you're trying to work on or correct

Explanation of Benefits (EOB): The information provided by the Payor explaining the payments (or lack thereof) for services rendered.

HIPAA (Health Insurance Portability & Accountability Act): The laws/privacy rules that must be followed when working with patient information

In-Network Providers (INN): Providers who have been credentialed with a particular Insurance Payor. INN Providers are usually reimbursed at a higher rate, and patients generally receive more coverage/payment when seeing an INN Provider.

Insurance Payors vs. Plans: Each insurance company is a Payor, and each Payor has different plans that they offer.

Modifiers: Two-character codes that provides more information about the encounter to the payor/plan

Out of Pocket Maximum (OOP): The limit on what a patient will be forced to pay out of their own pocket per each Plan/Calendar year. Once this is met, insurance will cover at 100%.

Out-of-Network Providers (ONN): Providers who have not been (or who have opted out) of being credentialed with a particular Insurance Company. ONN Providers are usually reimbursed at a lower rate, and patients generally receive less coverage/payment when seeing an ONN Provider.

Place of Service (POS): Where the services took place (office, telehealth, hospital, etc.)

Plan vs. Calendar Year Plans: A Calendar year plan runs from January 1st through December 31st while a Plan year plan will run for 12 months but will not necessarily start in January (ex: A patient's Plan year runs from April 1st through March 31st). Accumulations such as the patient's OOP Max and Deductible restart at the beginning of the new Calendar or Plan year

Prior-Authorizations: Authorization given by the Payor prior to services being rendered. Without one, services can/will be denied.

Scrubbing: The act of reviewing the claim and all its included information. Most EHRs do automatically, but still vital to review ourselves.

Visit Limits: When a plan limits the number of visits a patient may have per their plan/calendar year