2018 Emergency Department Definition Summit – Summary

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Abbreviations: Emergency department (ED), Emergency medical services (EMS),

TERM	NEW DEFINITION
CARE PROCESSES	
EMS off-loading	The process of transferring a patient from an EMS stretcher and placing the patient in a treatment space or triage. This is when care is assumed by the ED staff.
Identification	The process of collecting sufficient information critical to establish and record a unique patient encounter with at least two unique identifiers. This is a part of the patient registration process.
Triage	The process of clinically assessing patient acuity and identifying the providers, space, and resources needed for anticipated care.
Intake	The process of receiving, identifying, sorting, and ensuring the security of persons seeking access to care in the ED.
Registration	The process of identifying and recording information to generate a patient-specific record (patient identification) and collecting information on financial responsibility and sociodemographic statistics for billing.
Medical Screening Exam	A medical history, examination, ancillary tests and other medical determinations performed by a qualified medical provider (as defined under the Emergency Medical Treatment and Active Labor Act) to determine with reasonable clinical confidence whether an Emergency Medical Condition does, or does not exist.
Discharge	The process of releasing patients from the ED at the end of the encounter, including the distribution of discharge documents.
Decision to Admit	The formal affirmation by a clinician that the emergency care workup is complete such that the patient is ready for in-hospital admission.
Admission Accepted	The time when a patient is accepted for admission for bed assignment and care by an admitting service. This may precede the actual care handoff to the admitting service.
ED-to-Hospital Handoff	The process through which pertinent information regarding a patient's current clinical status is communicated to the inpatient staff accepting care of a patient being admitted.
ED Departure	The time when a patient physically leaves the ED after the encounter whether or not care has been completed. Potential destinations after departure include home, an outpatient care facility or physician's office providing specialized care (discharged patients); another medical facility (transferred patients), an in-hospital care unit at the same facility (admitted patients), or into the custody of another individual (law enforcement, case worker, child services, etc.).
Emergency Department Diversion	The process whereby an ED requests to be bypassed for EMS patient transports.
Hospital Diversion	The process whereby a hospital requests temporary diversion of a patient to other institutions for specific services that are temporarily unavailable. This may be caused by a limitation of institutional capacity to provide specialized care (intensive care, sub-specialist services, bed capacity, etc.) or a lack of a critical resource (e.g., out of service CT scanner).
Boarding	The time period when a patient admitted for in-hospital care remains in the ED after being admitted. This is the bed request-to-ED-departure time.
Observation	A care process where the patient has an in-hospital stay, billed as an outpatient service for additional treatment or diagnostic studies. This can occur for an ED patient after the completion of the ED encounter.
Overcapacity	The condition of having more patients than treatment spaces available.

Patient Segmentation/ Streamlining	The practice of separating or streaming patients into groups that require similar services and have similar anticipated lengths of stay.
Admission	Process of a patient transitioning from the ED to in-hospital care for treatment needed after the ED encounter. This may be for observation or inpatient status.
Boarding Problem	Prolonged admit-to-ED-departure time.
Intensive (Critical) Care	The specialized medical care of patients whose conditions are life- or limb-threatening, requiring high-intensity resources, complex care, constant monitoring, and frequent intervention.
Consult Call	The time a call for medical or surgical specialist consultation has been made.
Consult Order	The time an order to place a call for medical or surgical specialist consultation has been made.
Consult Call Response	The time a medical or surgical consultant responds to a call for consultation.
Consultant Arrival or Evaluation	The time a medical or surgical consultant is physically present in the emergency department for a consultation.
Consult Recommendations	The recommendations for care provided by a medical or surgical specialist consultant associated with the requested consultation.
Imaging Order Placed	The time an order for radiographic imaging is placed.
Image Protocoled	The time an order for radiographic imaging is protocolled.
Imaging Test Scheduled	The time a radiographic image is scheduled for imaging technologists to complete.
Patient Transported for Imaging	The time a patient is transported for radiographic imaging.
Image Start (or Initiation)	The time radiographic image acquisition begins.
Image Viewable to ordering Provider	The time a radiographic image is available for review by the ordering provider
Imaging Report (or Read) Viewable to ordering provider	The time the radiology report associated with a radiographic imaging test is available to the ordering provider.
Preliminary radiology read	The summarized, original radiographic report/reading communicated to the ordering provider and/or documented by the interpreting radiologist.
Final radiology read	The final, documented radiology reading of a radiologic image
First provider contact time	The time a provider capable of completing a medical screening exam and initiating an ED care plan first makes contact with a patient for initial assessment
Contested Admission	An admission where there is disagreement about the scope of workup required before admission acceptance and/or the disposition of an emergency department patient.
GENERAL CARE INTERVALS	
Arrival to Provider	The time from a patient's ED arrival to their first contact with a provider who can initiate their ED evaluation plan.
ED Length of Stay	The time from ED arrival time to ED departure.
Arrival to treatment space	The time from ED arrival to the patient being assigned and placed in a patient care space for evaluation.
Treatment Space to Provider	The time from a patient being assigned and placed into a treatment space to first provider contact.
First Provider Contact to Disposition	The time from first provider contact to the time a disposition decision is made.

Disposition to Departure	The time from when the disposition decision is made to when the patient physically departs from the ED.
Admit to Departure	The time from bed request for admission to ED departure.
Arrival to Triage	The time from a patient's ED arrival to the initiation of triage.
Triage to Roomed	The time from when a patient's ED triage is initiated (triage start) and when the patient is assigned and placed into a (non-triage) care space.
Roomed to Provider	The time from when a patient is assigned and placed in a treatment care space to their first contact with or evaluation with a provider who can initiate their ED care plan.
Provider Evaluation to Disposition Decision	The time between initial provider evaluation and when the disposition is set
Provider Evaluation to Testing Initiation	The time between the provider initiating their ED evaluation and when testing is initiated.
Testing Initiation to Testing/Evaluation Completion	The time from the initiation of ED testing and the completion of tests ordered for ED care.
Testing Completion to Disposition Decision "data to decision"	The time from when all testing is completed and when the disposition decision is been made.
Disposition Decision to Departure	The time from when a disposition decision has been made for a patient and their physical departure from the ED.
Decision to Admit to Admission Accepted	The time interval from when the decision to admit has been made and when the admission has been accepted for bed assignment and in-hospital care.
Admission Accepted to ED Departure	The time interval between acceptance of a patient for admission and the patient's physical departure from the ED.
Decision to Admit to ED Observation Order (for in ED observation)	The time from when the decision to admit a patient from the ED for in-hospital observation occurs and when an ED observation order is placed.
Decision to Discharge to ED Departure	The time interval between the decision to discharge a patient and when the patient physically departs the ED.
Triage to Provider	The time from when triage is initiated to when the provider evaluation begins.
Admission to Observation	The time from when a patient is admitted and when that patient is placed in observation.
Time to Treatment Space	The time between ED arrival and placement in a treatment space.
Care initiated to final disposition	The time from when care is initiated and the final disposition.
Laboratory Test Turn-around-Time	The time from the placement of an order for laboratory testing until the results are available to the ordering provider.
Lab Order to Collected	The time from ordering a lab and when it is collected.
Lab Collected to Received	The time from when a lab is collected by ED staff and when it is received by the lab.
Lab Received to Results	The time from when the lab receives a lab specimen and when results are provided.
Imaging Turn-Around-Time	The time from the placement of an order for an imaging test and when the results are available to the ordering provider.
Imaging ordered to Initiated	The time from when an imaging test is ordered to when the test is initiated.

Imaging Initiated to Preliminary Report	The time from when an imaging test is initiated to the preliminary report being available to the ordering provider.
Imaging Initiated to Final Report	The time from when an imaging test is initiated to the final report being available to the ordering provider.
ED Bed Cleaning Turn-Around-Time	The time from when a bed is vacated to when it is cleaned and ready for the next patient.
ED Bed Cleaning Request to Initiation	The time from when the ED bed, room, or care space cleaning request is placed to when cleaning begins.
Cleaning Initiation to Completion	The time from the initiation of ED bed, room, or care space cleaning to when it is completed.
Consult Turn-Around-Time	The time from when a consult is first placed to when the consult is completed.
Consult Initiation to Case/ Patient Evaluation	The time from when a consult is placed to when the patient is first evaluated by the consultant.
Case/Patient Evaluation to Consult Recommendations	The time from when the patient is first evaluated by the consulting specialist to when final consultation recommendations are provided.
Medical Stability/Cleared to initial behavioral health assessment	The time from when patient is considered medically stable or cleared for mental health services to when the first behavioral assessment begins.
Mental Health assessment to bed search time start	The time from when the mental health assessment is initiated to when the bed search begins.
Mental Health assessment to mental health disposition	The time from when the mental health assessment begins to the patient disposition.
Bed search time to mental health disposition	The time from when the bed search begins to the patient disposition.
TIMESTAMPS	
Arrival Time	The first evidence of a patient's physical presence in ED.
Triage Time	The time when comprehensive triage or intake is initiated by an institutionally credentialed provider.
Provider Evaluation Time/Contact Time	The time of a patient's first contact with a provider able to complete medical screening examination.
Testing Initiation	The time when the first diagnostic test is initiated.
Admission Ready	The time the ED provider caring for an ED patient determines the emergency care work up is completed and the patient is ready for a hand off to an in-hospital care team.
Admission Accepted	The time at which the ED provider speaks to and confirms from an inpatient provider acceptance of admission of a patient.
Departure	The time of the patient's physical departure from the ED.
Boarding	The time from the admission accepted to ED departure.
Treatment Initiated	The time associated with when a patient has testing and/or treatment initiated.
EMS ED Arrival Time	The time that EMS arrives in the ED with a patient as documented in the EMS record. As a result, it may or may not be the same as the "ED arrival time."

First Provider Contact time	The time a patient encounters a provider capable of completing a medical screening exam and initiating care.
Admit time	The first documented date and time of the disposition to admit the patient from the ED.
EMS Offload Time	The time that a patient is transferred from the EMS stretcher and placed in an ED treatment space as documented in the EMS record.
Nurse Contact Time	The time of first contact with a non-triage nurse (RN/LPN) in the ED to initiate patient care.
Treatment Space time	The time a patient is assigned and placed in an ED treatment space for provider evaluation.
Disposition Time	The time the patient disposition order (transfer, observe, admit, discharge, deceased) is placed
Diagnostic Test Data Ready Time	The time when all relevant testing and treatment results are available to the provider for decision making about patient disposition.
SPACE	
Emergency Department (ED)	A facility serving an unscheduled and undifferentiated patient population with anticipated needs for emergency medical, surgical, or behavioral health care. Such locations receive emergency medical service (EMS) transports 24 hours a day and 7 days a week. Reference the detailed EMTALA criteria for status as an emergency department.
Pediatric ED	A facility, or space within a larger ED, serving an unscheduled and undifferentiated patient population less than 18 with anticipated needs for emergency medical, surgical, or behavioral health care. Such locations receive emergency medical service (EMS) transports 24 hours a day and 7 days a week. Reference the detailed EMTALA criteria for status as an emergency department.
Psychiatric ED	A hospital location serving an unscheduled emergency behavioral health patient population that receives emergency medical service (EMS) transports 24 hours a day and 7 days a week. Reference the detailed EMTALA criteria for status as an emergency department.
Geriatric ED	A facility, or space within a larger ED, providing a multi-disciplinary team of care providers focused on providing the unscheduled and undifferentiated emergency medical, surgical, or mental health care needs of the geriatric population. Interdisciplinary teams may include physicians, specialized nurses, pharmacists, social workers, geriatric consultants, and care coordinators, quality and safety enhancements, among others. Care enhancements may include walled rooms, increased bedside provider availability, and detailed medication reconciliation.
Triage Area	The part of the intake where traditional triage assessment (e.g., history, focused physical exam, vital signs, illness acuity assessment) takes place.
Intake Area	The space where ED arrival activities - including entry security checks, identification, registration and triage - occur prior to placement into a treatment space, treatment room, or waiting area.
ED Treatment Room	A room within the ED in which full complete evaluation and treatment can be delivered to the patient.
ED Treatment Space	An area in the ED to which a patient can be assigned for care that is not enclosed with walls. It may not be suitable for complete evaluation and treatment. It may include hallways or group treatment areas.
ED Fast Track/Low Acuity Area	An area within or adjacent to the ED that is dedicated to the treatment of patients with minor illnesses, wounds, and injuries.

ED Clinical Decision Unit/Observation Unit	A specialized unit for the continued management of ED patients following their initial ED care; classified as in-hospital yet outpatient care. Note: not all ED observation patients receive care in an ED observation unit.
Results Waiting Area	The space where patients await diagnostic or consultative results after the initial assessment is completed and the care plan is initiated.
Discharge Waiting Area	The space allocated for ED patients who no longer need diagnostic or therapeutic interventions who are awaiting discharge (the process and/or paperwork).
Admission Holding Unit	The designated space, often within or adjacent to the ED, for ED patients awaiting admission processing and inpatient bed placement. The diagnostic and therapeutic needs of the patients at this stage no longer require an ED treatment room.
Discharge Check-Out	A specified area, usually adjacent to ED, where patients go through the discharge process including receiving instructions and prescriptions. Copayments may be made here.
PATIENT SUB-POPULATIONS	
Acuity	The general level of expected patient illness, urgency for clinical intervention, or intensity of resource use in an ED environment.
Admission rate	Percentage of ED visits admitted for in-hospital care, which may be designated as either observation or inpatient status.
Transfer rate	Percentage of ED visits transferred for care to another facility.
ICU Admission rate	Percentage of ED visits requiring an intensive care unit bed on admission.
Pediatric Volume	ED visits under age of 18 years.
Infant Volume	ED visits under age of <2 years.
Geriatric Volume	ED visits age 65 years or older.
MENTAL HEALTH PATIENT SUB-POPULATION	
Behavioral Health Patient	Any patient who presents and is dispositioned with a complaint primarily or secondarily consistent with a mental health illness and/or substance abuse disorder
Mental Health Patient	Any patient who presents and is dispositioned with a complaint primarily or secondarily consistent with a mental health illness (depression, suicidal ideation, psychosis, etc.)
Substance Abuse Patient	Any patient who presents and is dispositioned with a complaint primarily or secondarily consistent with substance abuse disorder (i.e. substance abuse overdose, alcohol abuse or intoxication, requests for detoxication, etc.)
ED STAFF	
Emergency Physician	Physician of record for emergency department patient encounters.
Emergency Medicine Physician	An emergency physician is defined as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.
Emergency Nurse	A nurse professional, working in an emergency department, who cares for patients with potential or confirmed medical, surgical, and behavioral health emergencies
Hospital Patient Flow Coordinator/ Bed Management	A person assigned and empowered to identify and allocate inpatient beds for admitted patients from the ED.

Call-Back Provider	Health care staff assigned to contact patients after an ED visit to inquire about the quality of the ED experience, the patient's condition, to communicate any results unavailable during the visit, or to collaborate subsequent care
Case Manager	A health care provider, typically a nurse or social worker, with training in case management. Duties may include reviewing cases for inpatient admission, facilitating bed placement, ensuring appropriate ED use, and arranging home care, follow-up care, transport, and nursing home care.
Crisis Worker	A licensed social worker with psychiatric experience who may be stationed within or on call to the ED to assist in evaluating and assisting in the disposition for patients presenting with behavioral health issues.
Discharge Team	A team of health care providers, typically a nurse and a technician, dedicated to the discharge process. The goals of the discharge team may include to expedite patient discharge, improve efficiency of ED throughput, and to ensure a satisfactory experience for patient and family.
ED Coordinator/ Patient Flow Coordinator	A health care provider, typically a nurse, dedicated to improve patient flow by providing oversight and assistance with ED dispositions. The PFC monitors for and seeks to improve ED process deficiencies, bottlenecks, waits, and delays.
ED Lab Tech	A lab technician stationed in the ED as part of the ED team who is responsible for collecting, labeling, transporting ED specimens to the lab and providing results to ordering ED providers.
Greeter	A non-licensed individual often stationed in the ED waiting area who provides information, comfort, and escort service for patients and their families.
Health Unit Clerk (HUC)	A person responsible for answering telephones, calling consulting physicians, maintaining charts, updating the patient log, and other clerical tasks as assigned.
Information Technology (IT) Support	An information technology specialist, or group of specialists, dedicated to supporting ED staff regarding information technology needs
Pharmacist	A licensed professional responsible for providing comprehensive clinical pharmacy services including therapeutic consultation and formulation.
Physician Assistant (PA)	A nationally licensed health care provider practicing medicine under the supervision of physicians. PAs are formally trained to provide diagnostic, therapeutic, and preventative health care services as supervised by a physician. They are also authorized to prescribe medications.
Primary Care Physician	A physician who provides and/or coordinates the overall health care for a patient.
Nurse Practitioner (NP)	A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. In some states NPs have license to practice and prescribe independent of a physician.
Advance Practice Provider (APP)	Licensed advanced practice professionals that include Nurse Practitioners (NPs) and Physician Assistants (PAs) who are credentialed to provide care alongside and in conjunction with emergency physicians in the care of emergency department patients. Another term for an Advanced Practice Provider is Advanced Practice Clinician (APC)
Pivot Nurse/Patient Segmentation Nurse	EM clinician (often an experienced RN or paramedic) positioned at the entrance of the ED to quickly identify patients who can proceed to triage or be placed directly into a room for care. This role is often used in large segmented EDs, and involves a provider quickly pre-

	triaging patients who can wait for triage/care as opposed to those who are too sick to wait for triage/care.
Scribe	An individual who assists the ED provider by documenting the patient assessment and treatment plan in the medical record. Scribes may also be assigned additional duties to facilitate patient flow by following up on diagnostic study results, chaperoning patient exams, implementing the treatment plan, and assisting with consults and other care processes
Transport Tech	A staff member who transports patients within the ED, or to other departments, for testing and treatment.
Valet	A service often stationed at the entrance of the ED, to physically assists fragile incoming and discharged ED patients to and from private vehicles. The valet will direct family members on parking, entry, and intake procedures. This is not to be confused with valet services outside of health care, whose function is to park cars.
Appeal	A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).
Applied to Deductible (ATD)	This is usually found on the patient statement. This is the amount of the charges, determined by the patient's insurance plan, the patient owes the provider. Many plans have a maximum annual deductible that once met is then covered by the insurance provider.
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.
Assignment of Benefits (AOB)	Insurance payments that are paid directly to the doctor or hospital for a patient's treatment. This is designated in Box 27 of the CMS-1500 claim form.
Authorization	When a patient requires permission (or authorization) from the insurance company before receiving certain treatments or services.
Average Age of Plant (years)	Indicates the financial age of the fixed assets of the hospital. The older the average age, the greater the short term need for capital resources.
Average Length of Stay (days)	The average stay counted by days of all or a class of inpatients discharged over a given period. Used as an indicator of efficiency in containing inpatient service costs. Formula= patient days ÷ total discharges
Average Payment Period (days)	A measure of how efficiently an organization pays its bills.
Balanced Bill	The balance remaining on the bill that your out of network insurance plan doesn't cover. This amount is the difference between the actual billed amount and the maximum amount an insurer will pay for a covered health care service ("allowed amount"), *excluding* your deductible and co- insurance. Charge minus (deductible + copay + insurer payment) = balance bill.
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.

Capital Expense (%)	A measure of the capital structure and the degree of flexibility an organization might have in raising capital.
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 five-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)	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 charge or a reduced charge to a patient that cannot afford to pay. The definition of charity care is based on local formulas that the hospital must follow and is the difference between the calculated cost of care and the amount the patient can pay.
Chart reconciliation	Chart reconciliation is the act of reconciling from a solid facility source log to ensure all billable patient visits performed by emergency providers were entered into the billing system. The reconciliation process is not completed until a second chart reconciliation is performed ensuring that any missing charts that have been requested have been received and entered into the billing system.
Claim	A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.
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 claim and checks for errors. This minimizes the amount of rejected claims as most errors can be easily corrected. Clearinghouses electronically transmit
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.
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 when employed but does benefit from the savings of being part of a group plan. Employers must extend COBRA coverage to

	employees who are dismissed. 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.
Coding	Medical Coding involves taking the patient's medical record and translating it into the proper evaluation and diagnosis (ICD-9 or ICD-10 code), treatment, such as CPT and quality codes. This is for the purposes including reimbursement, disease classification, and treatments.
Coinsurance	Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office.
Collection Per Visit	The average dollar amount collected per visit.
Complication of Pregnancy	Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.
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.
Copayment	A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
Cost-Sharing	Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.
Cost-Sharing Reductions	Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.
Covered Benefit	A health service or item that is included in your health plan, paid for either partially or fully. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.
CPT Code (Current Procedural Terminology)	This is a 5-digit code assigned for reporting a procedure performed by the physician. The CPT has a corresponding ICD-10 diagnosis code. It was established by the American Medical Association.
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 to the secondary insurance such as Medicaid.
Current Ratio (x)	This liquidity indicator shows the number of times short-term obligations can be met from short-term creditors. Because it provides an indication of the ability to pay liabilities, a high ratio number is one-way short-term creditors evaluate their margin of safety. Formula: total current assets ÷ total current liabilities
Cushion Ratio (x)	A measure of the capital structure of the organization. This ratio is important in evaluating the financial risk position of an organization. Formula: (cash and cash equivalents + board designated funds for capital) ÷ estimated future peak debt service
Date of Service (DOS)	Date that health care services were provided.
Day Sheet	Summary of daily patient treatments, charges, and payments received.
Days in Accounts Receivable	The days' sales in accounts receivable ratio, also known as the number of days of receivables, tells you the average number of days it takes to collect an account receivable. Since the days' sales in accounts receivable is an average, you need to be careful when using it.
Debt Service Coverage Ratio (x)	A ratio that measures the organization's ability to meet its debt repayments. A declining ratio number can indicate that an organization is in danger of becoming insolvent. Formula: net revenue available for debt service ÷ (principal payment + interest expense)
Debt-to-Capitalization (%)	Physical characteristics of a patient such as age, sex, address, etc. necessary for filing a claim. Formula: long-term debt ÷ (long-term debt + unrestricted fund balance)
Deductible	In health insurance, a deductible is the amount that a policyholder must pay each coverage period toward your medical expenses, before the insurance company begins to pay its share.
Demographics	Physical characteristics of a patient such as age, sex, address, etc. necessary for filing a claim.
Diagnostic Test	Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.
Discount	A prospective reduction to a patient's bill usually due to a prearranged contractual agreement between a hospital or doctor and the payor, typically an insurance company. A discount typically is either a fixed payment or a percentage reduction in the charge for a specific CPT code, procedure or diagnosis.
DME- Durable Medical Equipment	Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.
DOB	Abbreviation for Date of Birth.
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.
Durable Medical Equipment (DME)	Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.
Dx	Abbreviation for diagnosis code (ICD-9 or ICD-10 code).
E/M	The Evaluation and Management section of the CPT codes. These are the CPT codes 99201 thru 99499 most used by physicians to evaluate a patient’s treatment needs.
EBITDA	Earnings before interest, taxes, depreciation, and amortization
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.
Emergency Care Billing Provider	An individual that provides emergency care services. Some examples of emergency care providers include a doctor, nurse practitioner, and a physician assistant. Various regulations and policies may require the provider to be licensed, certified, or accredited as required by state law or hospital rules, regulations, or bylaws.
Emergency Department Evaluation and Management Services	An emergency service is any health care service provided to evaluate &/or treat any medical condition such that a prudent layperson, possessing an average knowledge of medicine and health, believes that immediate unscheduled medical care is required.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: 1. Placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment of bodily functions; 3. Serious dysfunction of any bodily organ or part.
Emergency Medical Transportation	Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.
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 patient's 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.
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.
Excess Margin (%)	This measure goes beyond the operating margin to include all sources of income and expenses. Other sources of income besides those from patient care operations have become increasingly important to hospitals.
Excluded Services	Health care services that your plan doesn't pay for or cover.
Explanation of Benefit (EOB)	The notice you receive from your insurance company after getting medical services from a doctor or hospital. It tells you what was billed, the payment amount approved by your insurance, the amount paid, and what you have to pay.
Explanation of Medicare Benefits (EOMB)	The notice you receive from Medicare after getting services from your doctor or hospital. It tells you what was billed to Medicare, Medicare's approved payment, the amount Medicare paid, and what you have to pay. Also called a Medicare Summary Notice (MSN).
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.
Federal Poverty Level (FPL)	A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.
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.
Financially Responsible Party	The person(s) responsible for paying your hospital or bill--also referred to as the guarantor.
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. A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.
Fraud	When a provider receives payment or a patient obtains services by deliberate, dishonest, or misleading means.
GHP- (Group Health Plan)	A means for one or more employer who provide health benefits or medical care for their employees (or former employees).
Grievance	A complaint that you communicate to your health insurer or plan.
Gross Collection Ratio	The gross collection ratio is shockingly low for many practices. The percentage of collections based on the gross charges varies significantly by practice and specialty. It is influenced by a number of things. The first is where the practice sets its fee schedules. Fee schedules which are set at a much higher rate than reimbursement allowances result in a lower gross collection rate. Many third-party contracts with low reimbursement rates will also affect the ratio. The greater the percentage of Medicaid patients in the practice, the lower the gross collection ratio will be. Also, surgical practices tend to have a much lower collection rate than primary care practices. (Gross Collection Ratio = Payments ÷ Charges)
Gross margin	Indicates how much profit a company makes after paying off its Cost of Goods Sold It is a Measure of the efficiency of a company using its raw materials and labor during production process. The higher the profit margin, the more efficient the company.
Group name	Name of the Group of insurance plan that insures the patient.
Group number	A number given to a patient by their insurance carrier that identifies the group or plan under which they are covered.
Guarantor	A responsible party and/or insured party who is not a patient.
HCFA (Health Care Financing Administration)	Now known as CMS
HCPCS (Health Care Financing Administration)	Level I consists of the American Medical Association's Current Procedural Terminology (CPT) and is numeric. Level II codes are alphanumeric and primarily include non-physician services such as ambulance services and prosthetic devices, and represent items and supplies and non-physician services, not covered by CPT-4 codes (Level I).

	Level III codes, also called local codes, were developed by state Medicaid agencies, Medicare contractors, and private insurers for use in specific programs and jurisdictions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructed CMS to adopt a standard coding system for reporting medical transactions. The use of Level III codes was discontinued on December 31, 2003, in order to adhere to consistent coding standards.
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.
Health Insurance	A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a “policy” or “plan”.
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.
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.
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.
HIPPA (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.
Home Health Care	Health care services and supplies you get in your home under your doctor’s orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn’t include help with non-medical tasks, such as cooking, cleaning, or driving.
Hospice Services	Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
Hospital-Based Care	Patient care that involves the delivery of medical services, including monitoring, diagnostics, interventions, therapies, and resources typically administered in a structured, coordinated, team-based hospital setting.
Hospital Outpatient Services	Services of a hospital that do not involve a status of inpatient (e.g. office, urgent care, emergency department, Radiology department or Observation services).
ICD-10 Codes	The 10th revision of the International Classification of Diseases. This is a three to seven-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.
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 three to five-digit number. Has been generally replaced by 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 typically use any provider or hospital.

Individual Responsibility Requirement	Sometimes called the “individual mandate,” which stems from the Affordable Care Act, the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don’t have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.
In-network Coinsurance	Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.
In-network Copayment	A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.
Inpatient	A hospital status that designates the patient is no longer an outpatient and is now covered under Medicare Part A. With the advent of the Recovery Audit Contractors patients must meet certain specific criteria in order to be classified as inpatients. The Hospital is then reimbursed by Medicare under the DRG payment system
Insurance Company Down-coding	When the insurance company reduces the code (and corresponding payment amount) of a submitted service. This down-coding is inappropriate if the code is properly submitted and consistent with medically necessary patient care that was delivered, documented, and accurately coded.
IPA (Independent Practice Association)	An organization of physicians that negotiate contracts with managed care organizations
MAC	Medicare Administration
Maintained Bed Occupancy (%)	A measure of the volume and utilization of inpatient services. Formula: (patient days x 100) ÷ (maintained beds x 365)
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.
Marketplace	A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an “Exchange”. The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.
Maximum Out-of-pocket Limit	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.
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 was $63,750 over 6 years for Medicaid and $44,000 over 5 years for Medicare. Providers who have not implemented EHRs starting in 2015 have been penalized 1% of Medicare payments increasing to 3% over 3 years.
Medicaid	A state administered, federal and state funded insurance plan for low-income people who have limited or no insurance. The Medicaid program in Massachusetts is MassHealth.

Medical Assistant	A health care worker who performs administrative and clinical duties in support of a licensed health care provider such as a physician, physician's assistant, nurse, nurse practitioner, etc.
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 Coder	Analyzes patient charts and assigns the appropriate code. These codes are derived from ICD-10 and corresponding CPT treatment codes and any related CPT modifiers.
Medical Record Number	A unique number assigned by the provider or health care facility to identify the patient medical record.
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	A health insurance program for people age 65 and older. Medicare covers some people under age 65 who have disabilities or end-stage renal disease (ESRD).
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.
Medicare Part A	Also referred to as Hospital Insurance, it helps pay for inpatient care in hospitals and hospices, as well as some skilled nursing costs.
Medicare Part B	Helps pay for doctor services, outpatient care, and other medical services not paid for by Medicare Part A.
Medicare Part C (Medicare Advantage)	A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits.
Medicare Part D	Medicare Prescription Drug Plan (Part D). These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.
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.
Minimum Essential Coverage	Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.
Minimum Value Standard	A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan

	offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.
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.
MSP	Medicare secondary payer
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.
Net Collection Ratio	A term used in medical accounting to describe the amount of money collected on the agreed-upon fees charged. Net collections are usually lower than net charges (the total amount the provider agrees to accept as payment) and it is certainly lower than gross charges (the provider's total invoice amounts before insurance adjustments and other adjustments). The net collections rate is calculated by dividing payments received from insurers and patients by payments agreed upon with insurers and patients. A medical practice reports its net collections on the income statement along with gross charges, net charges and the gross collection rate. Formula: payments received from insurers and patients ÷ payments agreed upon with insurers and patients.
Net contribution margin	Net Sales minus the variable product costs and the variable period expenses. In accounting contribution margin is defined as revenues minus variable expenses. In other words, the contribution margin reveals how much of a company's revenues will be contributing (after covering the variable expenses) to the company's fixed expenses and net income. The contribution margin can be presented as 1) the total amount for the company, 2) the amount for each product line, 3) the amount for a single unit of product, and 4) as a ratio or percentage of net sales.
Net income	This is the bottom line of the income statement. It is the mathematical result of revenues and gains minus the cost of goods sold and all expenses and losses (including income tax expense if the company is a regular corporation) provided the result is a positive amount. If the net amount is a negative amount, it is referred to as a net loss.
Network	The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.
Network Provider (Preferred Provider)	A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."
Non-Covered Charges	Charges for medical services denied or excluded by your insurance. You may be billed for these charges.
Non-Participating Provider	A doctor, hospital, or other health care provider that is not part of an insurance plan's doctor or hospital network. Also called a non-preferred provider.
NOS (Not Otherwise Specified)	Used in ICD for unspecified diagnosis.
NPI Number (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.
Operating margin (%)	This profitability indicator shows the income derived from patient care operations. Profitability indicators measure the extent to which the organization is using its financial and physical assets to generate a profit.
Orthotics and Prosthetics	Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.
Out-of-network Coinsurance	Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.
Out-of-network Copayment	A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.
Out-of-network Provider (Non-preferred Provider)	A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".
Out-of-pocket Cost	A patient's expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus any other services that are not covered.
Out-of-pocket limit	The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.
Outpatient Care	Patient care that does not involve the delivery of resources, medical services, monitoring, diagnostics, interventions, and therapies typically administered in a structured, coordinated, team-based hospital setting.
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.
Participating Provider	A doctor or hospital that agrees to accept your insurance payment for covered services as payment in full, minus your deductibles, copayments and coinsurance amounts.
Patient Responsibility	The amount a patient is responsible for paying that is not covered by the insurance plan. Typically including deductibles, copayments, and co-insurance
Physician Services	Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.
Plan	Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

POS (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 doctor's office, 12 is for home, 21 is for inpatient hospital, etc.
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.
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	A decision by a health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.
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 that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.
Premium Tax Credit	Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.
Prescription Drug Coverage	Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.
Prescription Drugs	Drugs and medications that by law require a prescription.
Preventive Care (Preventive Service)	Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.
Primary Care Provider	A physician or other licensed independent practitioner who provides and/or coordinates the overall health care for a patient.
Primary Insurance Company	The insurance company responsible for paying your claim first. If you have another insurance company, it is referred to as the Secondary Insurance Company.

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	An individual's 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's Fee Schedule (charge-master)	List of charges for each CPT code for a provider's evaluation, treatment, or other services.
Reconstructive Surgery	Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.
Referral	A request from a health care provider enabling or directing a patient to receive assessment, care, or treatment from another health care provider.
Rehabilitation Services	Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
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 also 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. For example, the Emergency Department is typically 450
RVU (Relative Value Amount)	Relative value units (RVUs) are a measure of value used in the United States Medicare reimbursement formula for physician services as a component of the resource-based relative value scale (RBRVS). The number of RVUs is typically multiplied by a conversion factor (payment per RVU) to determine reimbursement rates.
Scrubbing	Process of checking an insurance claim for errors in the health insurance claim software prior to submitting to the payer.
Secondary Insurance	Extra insurance that may pay some charges not paid by your primary insurance company. Whether payment is made depends on your insurance benefits, your coverage, and your benefit coordination.
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.
Self-Referral	When a patient sees a specialist without a primary physician referral.
Skilled Nursing Care	Services performed or supervised by licensed nurses in the home or in a nursing home. Skilled nursing care is not the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

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	A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
Specialty Drug	A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.
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-10 diagnosis and CPT procedural codes. One of the most frequently used medical billing terms.
Supplemental Insurance	Additional insurance policy that covers claims from 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.
UPIN (Unique Physician Identification Number)	A six-digit physician identification number created by CMS. Discontinued in 2007 and replaced by NPI number.

Usual and Customary Rate for Emergency Care (UCR)	The eightieth (80th) percentile of all charges for the particular healthcare service performed by a health care professional in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by CMS (CCIIO) or the state insurance commissioner. The nonprofit organization shall not be affiliated with or financially supported by a health insurance company.
Utilization Limit	The limits that Medicare sets on how many times certain services can be provided within a year. The patient's 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-10-CM coding classification to identify health care for reasons other than injury or illness.
Workers Compensation	Insurance claim that results from a work-related injury or illness.
Write-off	A retrospective reduction in charge. This typically refers to the difference between what the physician charges and an agreed-upon lesser amount.
EMERGENCY SERVICE UNITS	
Electrocardiograms (ECGs)	Number of ECGs performed per 100 ED visits.
Plain radiography studies	Number of plain film studies (not images) per 100 ED visits.
CT studies	Number of contrasted and non-contrasted CT studies (not images) per 100 ED visits. Includes CT-guided procedures.
MRI studies	Number of MRI studies (not images) per 100 ED visits.
Ultrasound studies	Number of formal ultrasound studies (not images) performed by the radiology department and reported to the ED per 100 ED patients.
Bedside ultrasound studies	Number of ultrasound studies (not images) performed at the bedside by the emergency care provider per 100 ED visits. These studies would be defined as having a billable limited study code and retained image(s) in the medical record.
Laboratory studies	Number of patients per 100 ED visits who have any specimen ordered and sent to the laboratory for processing or for recording as a billable laboratory test (this would include any point of care test in which docking resulted in the capture of the order and result and therefore would be eligible for a billable test).
Medication dosages	Number of medication doses administered by any route (intravenous, oral, intranasal, or intramuscular) per 100 ED visits. Total doses may be captured from an electronic dispensing system or from charges recorded by the pharmacy department.
Intravenous medication dosages	Number of intravenous medication doses administered per 100 ED visits. This would be a subset of total medication dosages and may offer some comparison of patient acuity.
Behavioral health consultations	Number of behavioral health consultations per 100 ED visits. This would be a marker of the mental health burden on the ED
Telemedicine behavioral consultations	Number of behavioral health consultations performed via telemedicine route per 100 ED visits. This would be a subset of the total behavioral health consultations listed above.
Social services/case management consultations	Number of social worker services and case management consultations arranged through the ED per 100 ED visits.

Case management consultations	Number of case management consultations per 100 ED visits, as a marker for discharge and admission decision burden on the ED.
Palliative care consultations	Number of palliative care consultations arranged through the ED per 100 ED visits.
Specialty service consultations	Number of medical or surgical specialty consultations arranged through the ED per 100 ED visits.
EMERGENCY STAFFING UNITS	
Clinical nursing hours worked	Number of scheduled clinical nursing hours divided by the number of clinical nursing hours worked per 100 ED visits.
Non-nursing caregiver hours	Number of scheduled non-nursing caregiver hours divided by the number of worked non-nursing caregiver hours.
Ratio of worked hours to patient hours	Total number of provider and staff direct care (i.e., contact hours) worked hours divided by the total number of patient hours for a given time period (monthly/annual).
Ratio of worked provider hours to patient hours	Total number of direct worked provider hours divided by the total number of patient hours for a given time period (monthly/annual).
Number of nursing hours	Total number of direct care clinical nursing hours per 100 ED visits.
Number of non-nursing caregiver hours	Total number of direct care non-nursing caregivers hours per 100 ED visits.
Staff hours per ED visit	Total number of staff hours as defined as nurses and non-nursing caregivers doing clinical work per ED visit.
Number of physician hours per ED visit	Total number of physician hours per 100 ED visits.
Number of advanced practice provider hours	Total number of advanced practice provider hours per 100 ED visits.
Number of case management hours	Total number of non-utilization case management hours per 100 ED visits.