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Driving Revenue Cycle Performance

Glossary of Common Healthcare RCM Terms

Claim A request by a patient (or his or her provider) to that individual's insurance company to pay for services obtained from a healthcare professional, or an itemized statement of healthcare services and their costs provided by a hospital, physician's office, or other provider facility. Claims are submitted to the insurer by either the patient or the provider for payment of the costs incurred.

Claim Denial The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for healthcare services.

Copayment Fixed amount owed for a healthcare service, due at the time the services are provided. Technically a form of coinsurance, the copay must be paid before any policy benefits are payable by an insurance company.

Deductible The amount owed by the patient for healthcare services before the plan begins to pay. Depending on the plan, some services may be covered before the deducible is met, and after many plans require patients to share in the cost via coinsurance.

Fee-for-Service A method in which doctors and other healthcare providers are paid for each service performed. Examples of services include tests and office visits.

Financial Policy Written policy developed by a healthcare organization that outlines its revenue cycle management process and sets expectations for patients about their financial responsibility for services rendered. This should be clear and concise, and reviewed with every patient before providing care.

Healthcare Revenue Cycle All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.

4135 South Stream Blvd
Suite 400
Charlotte, NC 28217

p (877) 615-6360
f (704) 512-0133
meduitrcm.com

ICD-10 Code The Internal Classification of Diseases, 10th Edition, is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care.

Insurance Eligibility Verification Real-time verification of a patient's insurance coverage and benefits from private or government payers.

Out-of-Pocket Costs Expenses for medical care that are not reimbursed by insurance. These costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered.

Patient Account Detailed record of patient demographic information, medical histories, and insurance coverage. An account is the means of tracking a patient's entire episode of care through the healthcare revenue cycle.

Patient Responsibility The out-of-pocket costs not covered by a third-party payer, or the amount owed by the patient for services not covered by their insurance plan. This is the amount of the bill the patient is responsible for after insurance determination has been made. (See also: Self Pay)

Payer Mix The percentage of revenue coming from private insurance vs. government insurance vs. self pay.

Self Pay Balances due from patients for healthcare services as a result of having no insurance, or having a balance due even after insurance pays due to coinsurance, deductibles, or uncovered services. (See also: Patient Responsibility)

Value-Based Payment Strategy used to promote quality and value of healthcare services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments, to payments that are more closely related to outcomes.

This information is not intended to be legal advice and may not be used as legal advice. Legal advice must be tailored to the specific circumstances of each case. Every effort has been made to assure this information is up-to-date as of the date of publication. It is not intended to be a full and exhaustive explanation of the law in any area, nor should it be used to replace the advice of your own legal counsel.

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