Glossary

Glossary Notes: The WBT course glossary will contain certain important terms that are defined and used in the WBT course. Every pop-up definition within the WBT course will be listed. Other terms that are defined within the text will also be listed. Related terms, or variants of terms that are defined may also be included in the glossary (e.g., “assigned claim” and “assigned provider”).

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835 - commonly referred to as “the 835,” the Accredited Standards Committee (ASC) X12N 835 Version 004010A1 is a variable-length record designed for wire (electronic) transmission of remittance data.

A

Adjustment - any change (including denials) that relates to how a claim is paid differently from the original billing.

Allowed Amount - the allowable reimbursement amount for the covered services, which may include any deductible for which the beneficiary is responsible.

Appeal - a special kind of complaint that the provider may be entitled to make if he or she disagrees with a decision to deny or reduce payment for an item or service that he or she provided to a Medicare beneficiary.

Assigned Claims - a claim submitted to Medicare by a professional provider who agrees to accept the Medicare-approved charges as payment in full for the rendered services.

Assigned Provider - a provider who accepts direct Medicare payments instead of billing the beneficiary.

Assignment - a category that indicates that a provider agrees to accept Medicare’s fee as full payment. The beneficiary may be responsible for coinsurance and/or deductible amounts.

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B

Beneficiary - a person eligible to receive Medicare or Medicaid payment and/or services.

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C

Carrier - a non-governmental organization or agency that contracts to serve as the fiscal agent and claim processor between professional providers and suppliers and the Federal Government.

Centers for Medicare & Medicaid Services (CMS) - the Federal agency that administers the Medicare program, and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. CMS is responsible for the quality standards in health care facilities through its survey and certification activity. CMS is responsible for oversight of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the Healthcare Common Procedure Coding System (HCPCS) medical code set and the Medicare Remittance Advice Remark Codes (RARCs) administrative code set.

Claim Adjustment Reason Code (CARC) - a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is maintained by the Health Care Code Maintenance Committee.

Claim Level - the section of a Remittance Advice (RA) that provides information about individual claims.

Code - a date element that represents a standardized definition, reason, or condition that relates to the claim or service.

Contractor - see Medicare Contractor.

Coordination of Benefits (COB) - the process for determining the respective responsibilities for a medical claim of two or more health plans or insurance policies that cover the same benefits. If one of the plans is a Medicare health plan, Federal law may determine which plan pays first.

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D

Denial - the nonpayment of a processed claim for an identified coverage or medical necessity reason.

Department of Health & Human Services (DHHS) - the agency that administers many of the "social" programs at the Federal level regarding the health and welfare of the citizens of the U.S. It is the "parent" of CMS.

Durable Medical Equipment (DME) - any reusable medical equipment ordered by a physician for use in a beneficiary's home (e.g., walker, wheelchair, hospital bed).

Durable Medical Equipment Regional Carrier (DMERC) - a Medicare contractor that provides claims processing and payment of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

(DMEPOS) for a designated region of the country.

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E

Electronic Funds Transfer (EFT) - an electronic transfer of Medicare payments directly to a provider's financial institution.

Electronic Remittance Advice (ERA) - a Remittance Advice (RA) transmitted in an electronic format.

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F

Field - the location in the Remittance Advice (RA) that represents specific claim processing data.

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G

Group Codes - the codes used to identify either the financially responsible party or the general category of payment adjustment. A Group Code must always be used in conjunction with a Claim Adjustment Reason Code (CARC).

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H

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health & Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.

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I

Informational RA - a Remittance Advice (RA) sent to providers who do not accept assignment, and is not accompanied by payment (providers who do not accept assignment must bill the beneficiaries to obtain payment). An informational RA is identical to other RAs. However, an informational RA contains a Remittance Advice Remark Code (RARC) indicating that the provider does not have appeal rights.

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M

Medicare Administrative Contractor (MAC) - the new contracting organization that is responsible

for the receipt, processing, and payment of Medicare claims. In addition to providing core claims processing operations for both Part A and Part B, they will perform functions related to: Beneficiary and Provider Service, Appeals, Provider Outreach and Education (also referred to as Provider Education and Training), Financial Management, Program Evaluation, Reimbursement, Payment Safeguards, and Information Systems Security.

Medicare Contractor - a private health Insurer that processes Medicare claims and makes payments on Medicare's behalf to providers, suppliers, and beneficiaries.

> **Note:** In October 2004, Medicare began integrating Carriers and Durable Medical Equipment Regional Carriers (DMERCs) into a single new authority, called a Medicare Administrative Contractor (MAC).

Medicare Remit Easy Print (MREP) - a software program developed by the Centers for Medicare & Medicaid Services (CMS) that enables professional providers to read and print Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 835s.

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N

Non-Assigned Claim - a type of claim that may only be filed by a non-participating Medicare physician or applicable non-physician practitioner. When a non-assigned claim is filed, the provider's reimbursement is obtained directly from the beneficiary.

Non-Assigned Provider - a provider who does not accept direct Medicare payments and bills the beneficiary instead.

Non-Covered Charges - the charges not covered by Medicare, Medicaid, or private health insurance.

Non-Participating Provider - a provider who does not accept assignment on all Medicare claims. See also Non-Assigned Provider.

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P

Part A - referred to as "Hospital Insurance," helps cover services and supplies related to inpatient hospital stays; Skilled Nursing Facility (SNF) care following a related, covered three-day hospital stay; some home health care; and hospice care for the terminally ill.

Part B - referred to as "Medical Insurance," helps cover doctors' services, certain medical items, and outpatient care. Also covers medical services such as outpatient physical therapy and some home health care furnished by hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers when the beneficiary does not qualify for Part A benefits.

Payment Floor - the set period of time for which a claim is held before payment (if appropriate) is issued. The payment floor is 28 days for paper claims, and 13 days for electronic claims.

Physician - individual licensed under State law to practice medicine or osteopathy.

Professional Provider - an individual physician or other recognized health care practitioner, or a group of such individuals, or a supplier that submits claims to Carriers or Durable Medical Equipment Regional Carriers (DMERCs).

Provider - a physician, health care professional, hospital, or health care facility approved to furnish care to Medicare beneficiaries and to receive payment from Medicare.

Provider-Level Adjustments - adjustments that are not specific to a particular claim or service on the Remittance Advice (RA). These adjustments are indicated by the Provider-Level Adjustment Reason Code.

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R

Refund - an adjustment made at the provider level of the current payment to indicate changes that Medicare is making on a prior payment. For example, a provider requested by a Medicare contractor to refund an overpayment, could choose to have the overpayment taken out of the next payment.

Rejected Claim - a claim that is rejected due to technical errors, including missing or erroneous required data elements. These claims are not processed and do not generate a Remittance Advice (RA).

Remittance - the payment of a Medicare claim by a Medicare contractor.

Remittance Advice (RA) - a document that explains the reimbursement decision made by the Medicare contractor; this explanation may include the reasons for payments, denials, and/or adjustments for processed claims. Also serves as a companion to claim payments.

Remittance Advice Remark Code (RARC) - a code used within RA to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC).

Remittance Balancing - the act of reconciling (or settling) differences between payments shown on the Remittance Advice (RA) as compared to amounts actually billed by the provider.

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S

Service-Line-Level - the section of a Remittance Advice (RA) that provides information about individual services billed on a claim.

Standard Paper Remittance Advice (SPR) - a Remittance Advice (RA) transmitted in a paper format.

Supplier - an entity that provides Durable Medical Equipment (DME).

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T

Translator Software - any software application that converts the electronic flat file to a user-friendly format on the provider's computer screen (see Medicare Remit Easy Print).

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U

Unassigned Claim - a claim submitted to Medicare by a professional provider who has not agreed to accept the Medicare-approved charges as payment in full for the services rendered. Providers collect payment for unassigned claims directly from the beneficiary.

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W

Withholding - an act that occurs when a percentage of payment or set dollar amounts are deducted (adjusted) from the payment to the provider during claim processing that may or may not be returned depending on specific predetermined factors. The Remittance Advice (RA) contains Claim Adjustment Reason Codes (CARCs) explaining the reason for the withholding adjustment.

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