Glossary of Medical and Billing Terms*

Children's℠ Healthcare of Atlanta

Ambulatory Care
All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or in an inpatient setting.

Bad Debt
Income lost by a healthcare provider when a patient fails to pay the amounts owed.

Beneficiary
An individual who receives benefits from or is covered by an insurance policy or other healthcare financing program; also may be called a member.

Capitation
A set amount of money received or paid out, based on membership rather than on service delivered, usually expressed in units of per member per month (PMPM).

Care Management Organization (CMO)
Private health insurance plans that partner with the Georgia Department of Community Health to provide healthcare coverage to Medicaid and PeachCare members. The current CMOs are Amerigroup, PeachState and WellCare. The CMOs are responsible for enrolling members, creating a network of providers, and managing the care of their members through prior authorization and referral requirements.

Charity Care
Physician and hospital services provided to persons who are unable to pay for the cost of services, such as those who are low-income, uninsured or underinsured.

Coinsurance
A provision in a member's (or a covered insured's) coverage that limits the amount of coverage by the plan to a certain percentage, commonly 80 percent. Any additional costs are paid by the member out of pocket.

Co-payment
The portion of the medical expense that a member (or covered insured) must pay out of his or her own pocket. Usually a fixed amount, such as $20 or $30, for outpatient services provided to HMO members.

CPT-4
Current Procedural Terminology—Fourth Edition. A set of five digit codes that describe specific medical services or procedures. These are generally used by physicians for billing. Typically, CPT-4 codes are used as the basis for establishing maximum fee schedule amounts payable to physicians who opt to participate in a HMO or PPO network.

Deductible
The portion of a subscriber's (or member's) health care expenses that must be paid out of pocket by the member before any insurance coverage applies. Commonly $100 to $1,500. A deductible is not typically allowed in federally qualified HMOs and often not allowed under state HMO regulations; however, copayment requirements can achieve the same result. Most commonly associated with insurance plans and PPOs.

Effective Date
The date the insurance policy actually begins. Members are not covered until the policy's effective date.

EOB
Explanation of Benefits statement. A statement mailed to a member or covered insured explaining why a claim was or was not paid.

Fee for Service
A method of billing for health services in which a physician or hospital charges separately for each patient visit or service provided.

Georgia Families
Georgia Families is a partnership between the Georgia Department of Community Health and private health plans (also called "Care Management Organizations" or "CMOs") to provide health care services to Medicaid and PeachCare members.

Health Savings Account
A savings account that members may contribute pre-tax dollars to for future medical, retirement, or long-term care premium expenses. To open an HSA, a member must be enrolled in a High Deductible Health Plan.

HMO
Health Maintenance Organization. Prepaid organizations that provide health care services in return for a preset amount of money on a per member per month (PMPM) basis.

ICD-9-CM
International Classification of Diseases, 9th Revision, Clinical Modification. The classification of disease by diagnosis, codified into five-digit numbers. Frequently used by hospitals for billing purposes.

Indigent Care
Health services provided to the poor or those unable to pay.

Inpatient
A patient who has been admitted at least overnight to a hospital or other health facility.

Katie Beckett Children
Disabled children who qualify for homecare coverage under a special provision of Medicaid named after a girl who remained institutionalized solely to continue Medicaid coverage.

Managed Care
Any healthcare plan that offers one or more of the following characteristics: a defined network of providers; financial systems that integrate discounted, flat rate or capitated reimbursement mechanisms to providers; formal utilization management features; and a means to measure the quality of care provided to enrollees. Such plans, in effect "manage" care by controlling the selection and utilization of and provide for a predetermined level of benefit coverage.

Medicaid
A U.S. government program that provides medical benefits for certain low-income and/or disabled persons in need of health and medical care. The program is funded by both the federal and state governments. In Georgia, many Medicaid members are enrolled in one of three Care Management Organizations (CMOs) that provides their healthcare benefits. Prior authorization may be required to obtain services through Medicaid and the CMOs.

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Medicare
A U.S. health insurance program for people age 65 and older, for persons eligible for Social Security disability payments for two years or longer, and for certain workers and their dependents who need a kidney transplant or dialysis. The program is made up of hospital insurance (Part A) and medical insurance (Part B).

Network
A group of doctors, hospitals and other healthcare providers contracted to provide services to insurance companies' members for less than their usual fees. Provider networks can cover a large geographic market or a wide range of healthcare services. Insured individuals typically pay less for using a network provider.

Open Enrollment Period
The period when an employee may change health plans. Usually occurs once each year. A general rule is that most managed care plans will have about one-half of their membership up for open enrollment in the fall, for an effective date of January 1.

Out-of-Pocket Maximum
A limited amount of money that an individual must pay out of his own savings, before an insurance company or (self-insured employer) will pay 100 percent for an individual's healthcare expenses. These maximums are typically applied on an annual and/or lifetime basis.

Outpatient
A patient who receives healthcare services (such as surgery) on an outpatient basis, meaning he does not stay overnight in a hospital or inpatient facility.

PCP
Primary Care Physician. Generally applies to internists, pediatricians, family physicians, general practitioners and obstetricians/gynecologists.

Point-of-Service Plan (POS Plan)
A plan where members do not have to choose how to receive services until they need them. A common example is a simple PPO, where members receive coverage at a greater level if they use preferred providers than if they choose not to do so. Less common examples include an HMO Swing-out, a Point-of-Service HMO, and Out-of-Plan Benefits Rider to an HMO or a Primary Care PPO. These are plans that provide a dramatic difference in benefits (e.g., 100 percent coverage versus 60 percent) depending on whether the member chooses to use the plan (including its providers and compliance with the authorization system) or go outside the plan for services.

PPO
Preferred Provider Organization. A plan that contracts with independent providers at a discount for services. The panel is limited in size and usually has some type of utilization review system associated with it. A PPO may be risk bearing, like an insurance company, or may be non-risk bearing, like a physician-sponsored PPO that markets itself to insurance companies or self-insured companies via an access fee.

Premium
Fees paid to an insurance plan for healthcare benefits for a defined time period. Fees may be paid by individuals, employers, unions or shared by these groups.

Primary Care
Basic or general healthcare focused on the point at which a patient ideally first seeks assistance from the healthcare system. This type of care is generally provided by physicians but also may be provided by nurse practitioners or physician assistants.

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Prior Authorization/Precertification
An approval from the health insurance plan is required before providing a particular service or procedure. If approval is not received and the service is performed, the provider may not be paid for the service, and you may be responsible for payment of the charges.

Provider
A term used for health professionals who provide healthcare services. The term may refer to physicians and other healthcare professionals such as hospitals, nurse practitioners, chiropractors, physical therapists and others offering specialized healthcare services.

Reimbursement
The process by which healthcare providers receive payment for their services.

Referral
The process of sending a patient from one healthcare provider to another for services.

State Children's Health Insurance Program (SCHIP)
A government health insurance program for children whose family incomes are too high to qualify for the Medicaid program. In Georgia, this program is called PeachCare, and members pay monthly premiums and receive similar benefits to those in the Medicaid program. Many PeachCare members are enrolled in one of three Care Management Organizations (CMOs) that provides their healthcare benefits. Prior authorization may be required to obtain services through PeachCare and the CMOs.

TRICARE
The healthcare program for members of the U.S. military, eligible dependents and military retirees. TRICARE was formerly called CHAMPUS (Civilian Health and Medical Program of the Uniformed Service).

**Terms were adapted from glossaries provided by the Health Insurance Resource Center and Academy Health ("Glossary of Terms Commonly Used in Healthcare")*

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