Glossary of Billing Terms

1500 Form – the uniform medical billing form used by physicians, suppliers (such as Durable Medical Equipment or DME companies), and other non-institutional providers to bill insurers for services rendered.

837 File – an electronic file version of the UB-04 form; the standard format used by institutional providers to transmit a UB-04 electronically.

837-P File – an electronic file version of the CMS-1500 form; the standard format used by non-institutional providers to transmit a 1500 electronically.

Charge Description Master (CDM) – also referred to as the Chargemaster, is the comprehensive list of all the billable services and items to a patient or a patient's health insurance provider. The chargemaster captures the costs of each procedure, service, supply, prescription drug, and diagnostic test provided at the hospital, as well as any fees associated with services, such as equipment fees and room charges.

Copay – or copayment, is a fixed amount paid by an insured for covered services, usually collected at the time of service. The amount can vary by the type of covered healthcare service and is a standard part of many health insurance plans. Insurance companies often charge copays for things such as doctor visits or prescription drugs.

CPT Codes – stands for Current Procedural Technology codes, a standardized coding system used to classify medical procedures and services performed in an outpatient setting.

Explanation of Benefits (EOB) – a statement sent by the insurance company to the insurer explaining the total charges for the healthcare services provided, how the insurance company processed the claim, how much the health insurance company paid and how much the patient owes for the services provided.

Facility Fee – a fee that a hospital or health system charges for outpatient services designed to cover the operational expenses required to provide services, from nursing staff, lab, and x-ray technicians, to housekeeping staff and parking attendants.

Hard Coded – the process of automatically assigning codes through charge entry process (without human intervention), which applies codes using the chargemaster, most often used for simple services where code values rarely change.

HCPCS Codes – stands for the Healthcare Common Procedure Coding System, a standardized coding system categorized into two levels: Level I (also known as Current Procedural Technology, or CPT codes) and Level II codes, used to identify products, supplies and services not included in CPT.

ICD-10-CM Code – stands for the International Classification of Diseases, Tenth Revision (ICD-10), a standardized coding system used to classify all diagnoses. Diagnosis codes are required on a medical claim to determine whether the patient's diagnosis(es) are medically necessary to justify the services received.

Medical Coding Modifier – a two-character alphanumeric value appended to a CPT or HCPCS code to provide additional information about the medical procedure, service, or supply without changing the meaning of the code. Modifiers provide a mechanism to communicate special or specific circumstances related to the performance of a procedure or service.

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Outpatient Prospective Payment System (OPPS) – the system for payment used by CMS to reimburse for hospital outpatient services. All items and services paid for under the OPPS are assigned a payment group called Ambulatory Payment Classifications (APCs) which group together items and services that are similar clinically and in terms of resource use.

Place of Service Codes (POS) – a two-digit code placed on a 1500 claim form to indicate the setting in which the professional healthcare services were provided. The Centers for Medicare and Medicaid Services (CMS) mains the standardized POS codes used throughout the healthcare industry.

Professional Fee Coding – also known as profee coding, refers to the process of coding and billing the services provided by individual healthcare professionals. Profee coding covers the work performed by the provider and the associated reimbursement they will receive for the services provided.

Prospective Payment System (PPS) – a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation services, long-term care hospitals, and skilled nursing facilities.

Revenue Code – a 4-digit code (including a leading zero) that indicates the type or location of the service or item the patient received. Standard revenue codes are used to group similar types of charges together. For example, Rev Code 0450 is used for Emergency Room (ER) services. Revenue Codes are mandatory for hospital billing and are paired with procedure codes.

Soft Coded – the process of manually reviewing associated documentation and assigning the appropriate code(s), most often used when the procedure or services being coded have a high rate of variability, such as complex procedures and surgeries.

UB-04 Form – the uniform medical billing form (or UB for short) is the standard claim form used by institutional providers to bill insurers for services rendered. Examples of institutional providers include hospitals, outpatient physical therapy services, skilled nursing facilities (SNF), and hospices.