

Generally Accepted Insurance Terminology

Allowed Charge (i.e. approved charge, covered charge, reasonable charge, usual & customary, U&C)

The maximum allowable dollar amount that an insurance company approves for reimbursement. This amount is determined by the policy set by your insurance carrier and based on procedure code (CPT) descriptions for the service. The allowed charges may not be the same as your invoiced amount due to the nature of the testing performed.

Balance Billing

Under certain circumstances, a healthcare provider may bill you directly for fees associated with any charges not covered by your insurance company. It is important to check with your insurance company to verify that your claim was processed correctly.

Cap / Capitation

A system in which your insurance pays a set dollar amount to a contracted laboratory based on the number of members rather than the services provided.

Claim

A financial statement describing medical services that is submitted to an insurance company for payment.

Claim Adjustment Code

A series of codes, used by the insurance companies, to identify and describe the reasons for the difference between the amount charged for a service by the healthcare provider and the amount covered.

Co-insurance

Often a percentage of the allowable charge, the co-insurance is the amount that the patient must pay after the deductible has been met.

Co-payment

A set dollar amount that must be paid towards a specific type of service (i.e. \$10.00 co-payment / office visit). Many insurance companies use the term co-payment to include both the co-insurance and co-payment owed by the patient.

CPT (Procedure) Code

Current Procedural Terminology (CPT) codes are five-digit codes maintained by the American Medical Association used to describe a service or procedure. CPT codes may only be generally descriptive, so multiple codes may be used multiple times to fully describe a medical service. Your insurance company uses these codes to help establish their allowable charge.

Deductible

A set dollar amount established by your insurance contract that must be paid toward the cost of medical treatment before insurance benefits are paid. Different deductibles may be required depending on whether the provider of the service is in or out of the insurance network.

Dependent

An individual (usually a spouse or child) other than the subscriber covered under an insurance contract.

DOS (Date of Service)

The date on which medical care was provided or blood drawn for laboratory testing.

EOB (Explanation of Benefits)

A report provided by the health insurance company summarizing how a claim reimbursement or denial was determined.

Exclusions

Specific services, procedures or medical conditions that an insurance policy will not cover, or only cover with limitations.

Experimental, investigational or unproven procedures

Some procedures are sometimes considered as unnecessary by your insurance company. These procedures may appear as “Experimental”, “Investigational”, or “Unproven Procedures” on an EOB report as a reason for a denial of services. New technology, procedures and services may require additional explanation or a letter from your physician prior to the reimbursement of your claim. ***The fact that a plan may not pay for a particular item or service does not mean that it is inappropriate for your medical care. This is determined by your physician.***

Fee Schedule

The maximum dollar amount a plan will pay for medical services. (see Allowed Charge).

Medically Necessary

Your insurance carrier determines if medical services are necessary generally based on its own evaluation of whether these services are consistent with the symptoms or diagnosis of your condition, commonly accepted standards of medical practice, not solely for the convenience of the patient, and rendered in a cost-effective manner. ***The fact that a plan may not pay for a particular item or service does not mean that it is inappropriate for your medical care. This is determined by your physician.***

Nonparticipating provider (non-par)

A healthcare provider who does not have an agreement with the health plan or insurance carrier to participate within their network.

OON (Out of network) / OOP (Out of Plan)

Medical services rendered by a provider who does not have an agreement with your health plan or insurance carrier. Services may or may not be covered depending on your insurance policy.

Prior Authorization / Precertification / Referral

The process of obtaining an authorization or referral from certain health plans before medical services are rendered. Failure to obtain preauthorization often results in a financial penalty. The patient and / or ordering physician is responsible for obtaining this authorization. ***An authorization for a service is not a guarantee of payment for that service.***

Provider

Any healthcare professional or medical service facility rendering medical treatment.

Subscriber (enrollee, insured)

The individual who has contracted for insurance benefits under a healthcare plan.