

Insurance Claims Processing

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Insurance claims processing is a crucial aspect of the medical coding and billing process. It involves the submission, assessment, and settlement of claims for healthcare services provided to patients by healthcare providers. This process ensures that healthcare providers are reimbursed for the services they deliver to patients. Here is a detailed glossary of terms related to insurance claims processing:

1. Adjudication:

The process of reviewing a claim to determine the benefits payable under a patient's insurance policy.

2. Benefits Verification:

The process of verifying a patient's insurance coverage and benefits before providing healthcare services.

3. Clearinghouse:

An entity that processes and submits electronic claims to insurance companies on behalf of healthcare providers.

4. Coordination of Benefits (COB):

The process of determining the primary and secondary insurance coverage for a patient with multiple insurance policies.

5. CPT Code:

Current Procedural Terminology code used to describe medical procedures and services provided to patients.

6. Denied Claim:

A claim that has been rejected by an insurance company due to errors or lack of coverage.

7. Electronic Data Interchange (EDI):

The electronic exchange of healthcare information between providers, payers, and other healthcare stakeholders.

8. Explanation of Benefits (EOB):

A statement from an insurance company detailing how a claim was processed and any patient responsibility.

9. ICD-10 Code:

International Classification of Diseases, 10th Revision code used to classify diseases and medical conditions.

10. Medical Necessity:

The requirement that healthcare services provided to patients be appropriate and necessary for the

treatment of their medical conditions.

11. National Provider Identifier (NPI):

A unique identification number assigned to healthcare providers by the Centers for Medicare and Medicaid Services.

12. Out-of-Network:

Healthcare services provided by a provider who does not have a contract with a patient's insurance company.

13. Pre-authorization:

The process of obtaining approval from an insurance company before providing certain healthcare services to patients.

14. Remittance Advice:

A document sent by an insurance company to a healthcare provider explaining how a claim was processed and any payment made.

15. Secondary Payer:

An insurance company that covers healthcare costs after the primary insurance company has paid its share.

16. Timely Filing:

The requirement that claims must be submitted to an insurance company within a specified time frame to be considered for reimbursement.

17. UB-04 Form:

A standard claim form used by hospitals and other healthcare facilities to bill insurance companies for services provided to patients.

18. Utilization Review:

The process of reviewing healthcare services to ensure they are appropriate, necessary, and cost-effective.

These terms are essential for understanding the insurance claims processing in medical coding and billing. Mastering these concepts will help professionals navigate the complex world of healthcare reimbursement and ensure accurate and timely payment for services provided to patients.