MASTER THE LANGUAGE OF

DENIALS MANAGEMENT

A handy glossary of essential terms to help healthcare professionals tackle denials with confidence and clarity.

REVCO SOLUTIONS

A

ADJUDICATE

A decision has been made regarding the claim (approved, rejected, denied).

ALLOWED AMOUNT

The maximum amount a plan will pay for a covered healthcare service. May also be called:

- Eligible expense
- Payment allowance
- Negotiated rate

APPEAL

An appeal is a formal request for a third-party payer or insurance carrier to review a decision that denies a benefit or payment. Can be submitted by the patient or the provider.

B

BILLING FEE SCHEDULE

A listing of what the provider or practice charges for each service. In facility billing, this is referred to as "chargemaster."

C

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

U.S. federal agency that administers the nation's major healthcare programs. Partners with state governments to oversee programs including:

- Medicare
- Medicaid
- Children's Health Insurance Program (CHIP)
- State and federal health insurance marketplaces

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CLAIM ADJUSTMENT GROUP CODES

Codes that are internal to the X12 standard and generally assign responsibility for the adjustment amounts. The format is always two alpha characters:

- CO: Contractual obligation
- PR: Patient responsibility

CLAIM ADJUSTMENT REASON CODE (CARC)

Explains why a claim or service line was paid differently (adjusted) than it was billed.

- Assigned by a national Code Maintenance Committee under X12.
- CARCs never change; they can be deactivated, but a new number will be created with a new description.

CLAIM DENIAL

A denial is a payer's decision to not pay for services rendered to a patient. Denials happen after a claim is reviewed and processed.

CLAIM REJECTION

Claims that do not meet the basic eligibility, format, or completion requirements. Rejected claims are not considered "received" until they are resubmitted as new, corrected, complete claims. Rejected claims differ from denials because denials happen after a claim is processed while rejections happen before.

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CLEAN CLAIM

One that has checked all the boxes and is processed for reimbursement.

CLEARINGHOUSE

An institution that electronically transmits different types of medical claims data to insurance carriers. They are the middleman between the healthcare providers and the insurance payers. A clearinghouse checks the medical claims for errors, ensuring the claims can get correctly processed by the payer.

COORDINATION OF BENEFITS (COB)

The process of determining the order in which multiple insurance plans pay when a patient is covered by more than one payer, ensuring proper reimbursement and avoiding duplicate payments. Denials can occur if payer information is incorrect, outdated, or missing.

CREDENTIALING

The process of reviewing a practitioner's academic, clinical, and professional ability as demonstrated in the past to determine if criteria for clinical privileges are met.

CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES

Uniform language used by healthcare professionals to code medical services and procedures. The goal is to streamline reporting and increase accuracy.

D

DENIAL RATE

Percentage of claims denied by payers.

DIAGNOSIS CODE

A combination of letters and/or numbers used to classify diseases based on a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Derived from the International Classification of Diseases (ICD) coding system.

DIAGNOSTIC RELATED GROUP (DRG)

A classification system that groups inpatient hospital stays into categories based on diagnoses, procedures, age, sex, discharge status, and resource use. Each DRG represents a fixed reimbursement amount determined by the expected cost of care for patients within that group.

DRG DOWNGRADE

A payer's adjustment that reassigns a claim to a lower-paying DRG than what was originally billed, typically due to differences in clinical documentation, coding, or medical necessity validation.

E

ELECTRONIC DATA INTERCHANGE (EDI)

The electronic interchange of business information using a standardized format. This process allows one company to send information to another electronically rather than using paper.

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ELECTRONIC HEALTH RECORD (EHR) SYSTEM

EHR is a software that helps healthcare practices with billing and administrative tasks that generate patient records. Similar to Practice Management System.

EXPLANATION OF BENEFITS (EOB)

An explanation from a health plan to a provider about a claim payment. It explains how a health plan has adjusted claim charges based on factors like:

- Contract agreements
- Benefit coverage
- Expected copays and co-insurance

H

HARD DENIAL

Payer refusing to pay because the service is not covered. Difficult to correct or appeal.

HCFA-1500

Standard claim form physicians and suppliers use to bill outpatient services.

HEALTH MAINTENANCE ORGANIZATION (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work or contract with the HMO.

I

ICD-10

International Classification of Diseases, Tenth Revision – the standard for coding claims (diagnosis codes).

M

MANAGED CARE PLAN

A type of health insurance that provides care for members at reduced costs using contracts with healthcare providers and medical facilities, which make up the plan's network.

MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)

Used by CMS to reimburse physician services. The MPFS is funded by Part B and is composed of resource costs associated with physician work, practice expense, and professional liability insurance. Is typically based on state, and mostly outpatient care

MEDICAL NECESSITY

A standard used by a payer to determine whether treatment or services are appropriate and effective given a patient's health needs.

N

NATIONAL PROVIDER IDENTIFIER (NPI)

Unique identification number assigned to covered healthcare providers, plans, and clearinghouses. Used to simplify administrative and financial transactions under HIPAA. Similar to a Federal Identification Number.

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P

PAYER ENROLLMENT

Process by which a provider joins a health insurance plan's network. The process includes:

- Requesting participation in a payer network
- Completing credentialing requirements
- Submitting documents to the payer
- Signing a contract

PAYER CONTRACT

The contract a provider has with an insurance company (payer), in regard to what, how, etc. they will reimburse the provider services given to a patient.

PRACTICE MANAGEMENT (PM) SYSTEM

Similar to an EHR system, PMI is a software that helps healthcare practices with billing and administrative tasks that generate the patient record.

PRIOR AUTHORIZATION (PA)

Decision by a health insurer or plan that a service, treatment plan, prescription drug, or durable medical equipment is medically necessary. May be required before a patient receives certain services, except in an emergency. Even so, prior authorization isn't a promise that a health insurance or plan will cover the cost. Prior authorization may also be called:

- Preauthorization
- Prior approval
- Precertification

R

REMITTANCE ADVICE REMARK CODE (RARC)

A standardized code used by payers on Electronic Remittance Advices (ERAs) or Explanations of Benefits (EOBs) to explain claim payments or denials, providing additional context for adjustments. RARCs often appear alongside CARCs to clarify why a claim was paid differently than expected.

REFERRAL

A written order from a primary care physician (PCP) for a patient to see a specialist or get certain medical services. In many HMOs, patients must get a referral before receiving care from anyone except a PCP. If a patient doesn't get a referral first, the plan may not pay for services.

RETRO AUTHORIZATION

A process whereby the insurance company reviews a service that's already been performed to determine if it was both:

- Covered under the patient's insurance policy
- Medically necessary

S

SOFT DENIAL

Temporary; typically requiring a corrected claim in order to be paid; oftentimes due to human error

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T

TECHNICAL DENIAL

Medical necessity has been met however, the payer claims the provider failed to follow their guidelines.

TIMELY FILING LIMIT

The timeframe within which a claim must be submitted to a payer. Different payers have different timely filing limits to comply with procedural requirements.

U

UB-04

Standard claim form that providers use to bill Medicare, Medicaid and other insurance companies for facility and ambulance services

X

X12

A standards organization chartered by the American National Standards Institute. Develops and maintains the EDI that drives business processes globally.

#

835 FILE

Also known as Electronic Remittance Advice (ERA) which provides claim payment information and documents the EFT to the provider.

837 FILE

An electronic file that contains patient claim information submitted to insurance companies or clearinghouses instead of printing and mailing paper claims.

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NEED HELP MANAGING YOUR GROWING DENIALS?

- Reduce Write-Offs
- Simplify the Complex
- Prevent Future Denials

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