Arthrex RSP

Glossary

Reimbursement Glossary

Account Number: The number assigned by your provider (hospital, physician, etc) when medical services were provided.

Advance Beneficiary Notice (ABN): A written notification that Medicare will not pay for a service or supply; it includes the estimated out-of-pocket cost to the patient.

Allowed Amount: The maximum dollar amount that an insurance company will allow a provider to collect for an eligible health care service. Depending on the patient's particular coverage, this amount may be paid by the insurer or the patient, or split between them.

Ambulatory Payment Classification (APC): Payment methodology that bundles the reimbursement for all components of a procedure into one payment; used under Medicare's prospective payment system (PPS) for outpatient hospital services.

Ambulatory Surgery Center (ASC): A licensed facility that is not part of a hospital and has a primary purpose of providing elective surgical care. Patients are admitted to and discharged from the facility within 24 hours. ASCs are focused on providing same-day surgical care, including diagnostic and preventive procedures.

Appeal: The process by which a patient or provider attempts to persuade an insurer to pay for more (or, in certain cases, pay for any part) of a medical claim. The appeal on a claim only occurs after a claim has been denied or rejected.

Authorization: Many health insurance companies require patients to obtain permission before receiving hospital treatment. This is called the approval, authorization, or certification process.

Balance Billing: When the difference between the allowed amount and the charges from the provider is billed to the patient.

Certificate of Medical Necessity: A document that details the clinical history and previous therapies for a specific diagnosis or disease.

Charges: Amount the hospital charges for services, procedures, or supplies. Also referred to as "gross charges" or amount "billed." Typically, the charges are discounted or "adjusted" based on the insurance contract agreement or a self-payment discount.

Coding: A system used by insurers and providers to identify diagnoses and describe medical services and products provided by a health care provider when treating a patient.

Coinsurance: This portion of the hospital payment is the patient's/guarantor's responsibility. This amount is determined by their insurance policy and is usually based on a percentage.

Commercial Health Insurance: This is nongovernment insurance that pays all or some portion of medical bills. It may be purchased by individuals or employers and is most often obtained as an employment benefit.

Contractual Adjustment: This is the portion of a patient's bill that the hospital must write off because of a billing agreement with the patient's insurance company.

Coordination of Benefits (COB): The reimbursement relationship of insurance plans when a patient has more than one insurance policy. The reimbursement from all plans, for a specific service or procedure, may not equal more than the billed amount.

Co-payment: A flat dollar amount paid for each medical service provided to an insured person. Insurance companies use co-payments to share health care costs and prevent overutilization.

Coverage: The terms and conditions under which a payer will provide benefits for a specific treatment.

Current Procedural Terminology® (CPT®): CPT codes provide doctors and health care professionals with a uniform language for coding medical services and procedures. These codes help streamline reporting and improve accuracy and efficiency.

Deductible: The portion of any hospital bill that is not covered by the insurance company. It is normally quoted as a fixed amount per year and is a part of most health care policies. The deductible must be paid by the insured before the benefits of the policy can apply.

DOS: Refers to the date of service.

Diagnosis (Dx): Clinical determination of a patient's condition, sign, or symptom represented by the ICD-10-CM coding system.

Diagnosis-Related Group (DRG): A system of classifying medical cases for payment on the basis of diagnosis. Used under Medicare's prospective payment system (PPS) for inpatient hospital services.

Electronic Data Interchange (EDI): Computerized submission of health care insurance information exchange.

Experimental or Investigational Treatments: A drug, device, diagnostic procedure, treatment, preventive measure, or similar medical intervention that is not yet proven to be medically safe and/or effective. Services considered to be investigational are typically not covered by health insurance. If offered as part of a clinical research study, the study itself may cover the costs.

Explanation of Benefits (EOB): A notice sent from the insurance company to a patient and their provider after services are rendered. It details what was billed, the payment amount approved by insurance, the amount paid, and the amount due from the patient.

Fee for Service (FFS): A payment due to medical providers for individual services rendered.

Fee Schedule: A fee schedule is included in the provider's insurance company contract (except for Medicare and Medicaid) and states what the insurance company is willing to pay (allowed amount) for services the provider performs.

Global Period: The period of time during which claims for related services will be denied as a bundled component of the total surgical package. Major procedures have a global period of 90 days.

Healthcare Common Procedure Coding System (HCPCS): A three-level coding system, consisting of CPT, National or Level 2, and Local or Level 3 codes.

HCFA 1500 Form: An official standard form required by Medicare and Medicaid and used by some private insurance companies and managed care plans for billing. Physicians and other providers use this form—which contains patient demographics, diagnostic codes, CPT/HCPCS codes, diagnosis codes, and units—when submitting bills and claims for reimbursement to Medicare, Medicaid, and private insurers.

In-Network Provider: A doctor, or other health care provider, who is part of an insurance plan's network.

International Classification of Disease (ICD) Codes: ICD codes are an international disease classification system used in diagnosis and treatment.

Itemized Statement: An itemization of services provided, which includes the CPT and diagnosis codes submitted to an insurance plan. An itemized statement is not a bill.

Local Coverage Determination (LCD): A coverage policy established by a specific Medicare Administrative Contractor (MAC) that is effective in that MAC's district only.

National Coverage Determination (NCD): A coverage policy established by the Centers for Medicare & Medicaid Services (CMS) that is effective nationwide and supersedes any LCDs.

Medically Necessary: Health care services or supplies needed to prevent, diagnose, or treat an injury, illness, condition, disease, or its symptoms.

National Provider Identifier: The 10-digit number assigned to a provider by the CMS and National Plan and Provider Enumeration System (NPPES) and used for identification purposes when submitting services to third-party payers.

Network: The facilities, providers, and suppliers a health insurer or plan has contracted with to provide health care services at a discounted rate to the insurer

Out-of-Network Provider: A doctor, or other health care provider, who is not part of an insurance plan's network.

Out-of-Pocket Maximum: The cumulative coinsurance and co-pay dollars paid by a patient, within a designated timeframe, after which coverage shifts to 100%.

Prior Authorization: A requirement by the payer to receive advance written permission for patient services to be considered for payment.

Secondary Insurance: Additional coverage that may pay charges not covered by primary insurance. Payment is made according to the terms of a patient's policy and benefits and coordinated with the patient's primary insurance.

UB92/UB04: An official standard form required by Medicare and Medicaid and used by some private insurance companies and managed care plans for billing inpatient and outpatient hospital or facility charges. Physicians and other providers use this form—which contains patient demographics, diagnostic codes, CPT/HCPCS codes, diagnosis codes, and units—when submitting bills or claims for reimbursement to Medicare, Medicaid, and private insurers.

Usual, Customary, and Reasonable (UCR): Used by some third-party payers to establish a payment rate for a service in an area with the usual (standard fee in the area), customary (standard fee by the physician), and reasonable (as determined by the payer) fee amounts.

Additional Reimbursement Support Program Information

Arthrex Coding Hotline

- www.arthrex.com/reimbursement
- Access coding guides
- Review the FAQs page
- Send an email directly to the Arthrex Coding Hotline

Product-Specific Coding Hotlines

- Arthrex Coding Hotline (all products) | 844-604-6359
- Biovance® Human Amniotic Membrane and Interfyl® Connective Tissue Matrix | 844-963-2273 (prompt 5)
- Cartiform® Viable Osteochondral Allograft | 866-988-3491

Arthrex Reimbursement Support Program

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