Glossary

Billing in the context of this report is used to encompass the entire process of submitting claims to both insurance companies and patients. Claims on the other hand, as explained below, are the part of the process focused on sending invoices to insurance companies.

Centers for Medicare and Medicaid Services (CMS) is a federal agency that oversees Medicare and oversees the federal portion of Medicaid and the Children's Health Insurance Program (CHIP). Within the context of this report, CMS was referenced multiple times in relation to the requirements it sets, such as self-attestation, which requires clinicians to certify the completeness and accuracy of the information they are providing.

Claims or Medical Claims are invoices that the health facility that provided patient care sends to the insurance company of patients. Claims list codes that describe the care that patients received.

Codes or Coding refers to the process of translating a patient interaction into numbers that insurance companies use. Codes are standardized and updated frequently. More information on the specific types of codes referenced in this report will be listed below.

Current Procedural Terminology (CPT) codes are a standardized numeric system to record a type of medical service for billing. These codes are maintained by the American Medical Association and are usually five-digit numeric codes.

Denials are claims that were evaluated and denied based on a patient's policy.

Electronic Medical Records (EMR) is an electronic record of a patient's health-related information within one health care organization.

Formulary is a list of preferred prescription medicines covered by an insurance plan and sorts drugs into different tiers based on how much they cost and how one's health plan covers. Formulary is updated at least once a year and differs by insurance company.

Healthcare Common Procedure Coding System (HCPCS) codes are similar to the above-mentioned CPT codes, as in that they are a standardized system to record a medical service for billing. Unlike the CPS, however, HCPCS is maintained by CMS,

may include letters and numbers, and has two levels. HCPCS is also more expansive than CPT codes in the range of services listed.

International Codes of Diseases (ICD) are used to codify health conditions and diseases and procedures usually used in hospital settings and is administered by the World Health Organization (WHO). The United States is currently using ICD-10, released in 2015, while much of the rest of the world uses ICD-11. The ICD is updated twice a year, with major revisions occurring every ten years.

Managed Care Organizations (MCOs) are organizations that practice managed care principles which are "a health care delivery system organized to manage cost, utilization, and quality."[1] Examples include Blue Cross Blue Shield and Presbyterian.

Peer-to-peer requirement (P2P) are discussions between physician and an insurance company doctor during the prior authorization process, and have, according to some participants, increased in recent times. The P2P discussion involves the physician justifying the medical necessity of a treatment, procedure, and/or drug they are trying to get approved by patients' insurance companies and happens before patients are seen and/or treated.

Prior authorization (PA) requires providers to receive approval from a patient's insurance company before they can administer a certain medication, treatment, or care to ensure it is covered. According to participants, prior authorization is usually required for more specialized and costly care.

Rejections are claims that are returned before they could be processed due to errors.

The Revenue Cycle in healthcare includes every administrative and clinical process that is a part of collecting payment for patient services provided. Since this process is convoluted and lengthy, as will be evident in the findings section of the report below, we mapped out this process using both the findings from our interviews and previous studies including Tseng et al (2018).[2] We also added prior authorization, which is not necessarily part of the revenue cycle but another important consideration within the process.

[1] Medicaid.gov (n.d.) *Managed Care*. Retrieved from: https://www.medicaid.gov/medicaid/managed-care
[2] Tseng, P., R.S. Kaplan, B.D. Richman, M.A. Shah, K.A. Schulman (2018). Administrative Costs Associated with Physician Billing and Insurance-Related Activities at an Academic Health Care System. *JAMA 319*(7), 691-697.