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## **Insurance Terminology Defined**

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*Author's note:* Because I have been so busy these past two months, I decided this month's article would be an explanation of the following common insurance or insurance billing definitions.

If you would like me to provide more of these terms/definitions in subsequent articles, please let me know. I would like to offer my personal condolences and prayers to any and all of you or your loved ones who are suffering in any form or fashion because of the latest happenings in our country.

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**1. Adjuster:** The insurance company's designated person handling the patient's insurance claim. The adjuster investigates and pays or denies the claim. The adjuster is also the person to get authorization from prior to beginning treatment in a workers' compensation case.

**2. Allowed Charges:** The maximum amount, according to the individual policy, that the insurance will pay for each procedure or service performed.

**3. Assignment of Benefits:** The patient's signed permission for the provider to be paid directly, rather than sending payment to the patient.

**4. Authorization:** Permission from the insurance company to treat the patient. Authorization is also the patient's approval for you to release records, and for you to be paid directly for your services. For a workers' compensation case, most states require that you obtain authorization from the carrier/adjuster or case manager to treat the patient.

**5. Carrier:** The insurance company or self-insurers' fund.

**6. Case Management Services:** The process in which the attending physician or agent coordinates the care given to a patient by other health care providers and/or community organizations.

**7. Claim:** Demand by the insured to recover payment under an insurance policy.

**8. Claimant:** The employee injured on the job, once said employee has been accepted for medical and/or indemnity benefits by the workers' compensation system.

**9. Claims Attachments:** Additional claims documentation needed to adjudicate the claim.

**10. Claims Department:** The department of an insurance company that handles and services claims.

**11. Copayment:** Also known as co-insurance. The copayment is the portion the patient pays when his/her policy does not cover 100%. This amount is pre-established by the policy and is due at the time of the office visit.

**12. CPT™ Main Number:** The five-digit medical procedure code assigned in the Physicians' Current Procedural Terminology CPT™ coding system to identify a specific medical service.

**13. Customary Fees:** The average fee charged in a geographical area by all like providers, or the 90th percentile of all fees charged for a specific procedure by comparable providers in the same geographical area.

**14. Deductible:** Amounts payable by the policyholder before the insurance company is obligated to pay benefits. Pre-selected at the time of policy purchase.

**15. Dependent:** A person financially supported by the policyholder; meets the legal requirement for inclusion in a policy.

**16. Diagnosis:** The art or act of identifying a disease or illness based on its signs and symptoms. Only an MD or a chiropractor can provide a diagnosis. Massage therapist licenses do not allow for diagnosis. Important: be sure the diagnosis on MD prescription/referral, the body areas you treat, and what you document coincide with one another.

**17. Diagnostic Code:** The statistical code number assigned by the World Health Organization for a specific diagnosis. The number appears in the International Classification of Disease, 9th edition. Also called ICD,

or ICD-9-CM code. A physician assigns this code.

**18. Disability:** partial or complete inability to perform work duties.

**19. Disability Compensation Program:** Programs that reimburse insured workers' for loss of income due to injury or illness.

**20. Disability Insurance:** Reimbursement for lost income resulting from a temporary or permanent illness or injury.

**21. Documentation:** The process of record-keeping and documenting the patient's conditions; therapy; progress or lack of progress; recommendations; and patient management.

**22. Employer Self-Insured Programs:** Programs whereby employers with sufficient capital insure their own employees against loss of medical expenses and or wages, without contracting with a commercial carrier for coverage. Some of these companies contract with commercial carriers for the administration of their policies.

**23. Employer-Sponsored Group Health Plan:** A company-sponsored group health plan covering 50 or more employees. Primary to Medicare.

**24. ERISA - Employee Retirement Insurance Security Act (federal).** Self- insured employers, usually with a large number of employees, come under this act.

**25. Established Patient:** A patient who has an established chart and has received medical services within the last three years from the original physician, or from another physician of the same specialty in the same group practice.

**26. Explanation of Benefits (EOB):** Insurance company report to the patient or provider to explain the claims benefits paid, reduced or denied.

**27. Fee Schedule:** The schedule of fees that the insurance company lists in the policy, stating the maximum dollar amount the insurance company will allow for specific medical procedures performed.

**28. Fraud:** Deliberate misrepresentation of facts.

**29. Group Policy:** Written and purchased by an organization or association as a benefit for the employees or members. Employer, union, trade, professional, or other groups with common interests obtain group policies.

**30. Health Insurance:** A product written to provide protection against the policyholder's losses for the injury, illness or disability.

**31. Health care Provider:** Recognized licensed practitioner who provides health care to patients independently or pursuant, to the prescription of a physician. Florida LMTs, as well as massage therapists in other states such as Tennessee, are recognized health care providers of massage therapy services.

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\* Please notify me if your state recognizes massage therapists as health care providers.\*

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**32. HCFA 1500 Form: (Health Care Financing Administration.)** This is the claim form most widely accepted by insurance companies when billing for insurance-related services. Also known as the Universal Claim Form.

**33. HMO (Health Maintenance Organization):** A prepaid managed care, health care provider group practice with responsibility for providing health care services for a fixed fee to subscribers in a specific geographic location. Plan covers preventative services with little or no out-of-pocket expenses. In most cases, members must use the physicians and facilities authorized by the HMO.

**34. IME (Independent Medical Evaluation):** The examination an insurance carrier may require the patient to have performed by a physician other than the treating physician. This evaluation is used to make a judgment regarding the health-related status of the patient ,to determine the need for further medical services or to discontinue services.

**35. Individual Insurance Plan:** An insurance plan sold to individuals who are not eligible for medical insurance under a group policy, or to those who need more coverage than is available through their group plan.

**36. Insured:** The person in whose name the policy is registered, or the subscriber who contracts with an insurance company for insurance coverage. The insured is not necessarily the policyowner or the person being treated. The insured may also be a family member, dependent, or one given permission to drive your

automobile. In short, the insured is the person protected under a given policy.

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Click [here](#) for more information about Vivian Madison-Mahoney, LMT.



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