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Advanced Certificate in Healthcare Fraud Case Studies

## Healthcare Billing Practices

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**Advanced Beneficiary Notice (ABN):** A document that providers use to inform Medicare beneficiaries that a service may not be covered, and they may have to pay for it. Related terms include: Medicare, coverage determination, out-of-pocket costs. The ABN explains the reason for the potential non-coverage and provides an estimate of the cost to the beneficiary. It allows the beneficiary to make an informed decision about whether to receive the service, and if so, how they will pay for it.

**Bundled Payments:** A payment model where a single payment is made for a group of services related to a specific episode of care. Related terms include: fee-for-service, global period, alternative payment models. Bundled payments encourage providers to coordinate care and reduce unnecessary services, as they are responsible for the total cost of care within the bundled payment period.

**Chargemaster:** A comprehensive list of charges for all services, procedures, and items provided by a hospital. Related terms include: hospital billing, charge description master (CDM), fee schedule. The charge master serves as the basis for hospital billing, with charges for individual services or items often determined by complex algorithms.

**Claim:** A request for payment submitted by a healthcare provider to a health insurance company for services rendered to a patient. Related terms include: coding, billing, reimbursement. Claims include detailed information about the services provided, the provider, the patient, and the diagnosis and procedure codes used.

**Coding:** The process of assigning standardized codes to diagnoses and procedures for the purpose of billing and data analysis. Related terms include: ICD-10, CPT, HCPCS. Coding ensures consistency and accuracy in billing and helps payers determine the appropriate reimbursement for healthcare services.

**Compliance Program:** A set of policies and procedures designed to ensure adherence to laws, regulations, and ethical standards related to healthcare billing and reimbursement. Related terms include: fraud, waste, abuse, internal controls. Compliance programs help organizations prevent, detect, and correct non-compliant behavior, and may include training, auditing, and monitoring activities.

**Copy Testing:** The process of evaluating the content and clarity of explanation of benefits (EOBs) and other patient communications. Related terms include: patient engagement, transparency, health literacy. Copy testing helps ensure that patients understand their healthcare bills and can make informed decisions about their care.

**Cost Report:** A financial report submitted by healthcare providers to Medicare and other payers to determine reimbursement rates. Related terms include: Medicare cost reporting, provider reimbursement, fee schedule. Cost reports include detailed information about the provider's costs, revenues, and utilization, and are used to calculate the provider's cost-based reimbursement rate.

**Durable Medical Equipment (DME):** Medical equipment that is used in the home to provide therapeutic benefits to individuals with medical conditions or disabilities. Related terms include: home health care, prosthetics, orthotics. DME includes items such as wheelchairs, hospital beds, and oxygen equipment, and is often subject to specific coverage and reimbursement rules.

**Encounter Data:** Data collected by Medicare and other payers to track healthcare utilization and costs. Related terms include: claims data, electronic health records (EHRs), health information exchange (HIE). Encounter data includes detailed information about each healthcare encounter, including diagnoses, procedures, and costs.

**Fee Schedule:** A list of fees established by payers for specific healthcare services or procedures. Related terms include: reimbursement, payment rates, charge master. Fee schedules help ensure consistency and transparency in payment for healthcare services and are often based on Medicare's fee schedule.

**Global Period:** A period of time following a surgical procedure during which related services are included in the payment for the procedure. Related terms include: bundled payments, fee-for-service, postoperative care. The global period is designed to encourage providers to coordinate care and reduce unnecessary services following a surgical procedure.

**Healthcare Common Procedure Coding System (HCPCS):** A standardized coding system used to describe medical procedures and services for the purpose of billing and reimbursement. Related terms include: CPT, ICD-10, coding. HCPCS includes both current procedural terminology (CPT) codes and level II codes used for durable medical equipment (DME), prosthetics, orthotics, and other items.

**Health Insurance Portability and Accountability Act (HIPAA):** A federal law that establishes standards for the privacy and security of protected health information (PHI). Related terms include: PHI, electronic health records (EHRs), data breaches. HIPAA requires healthcare providers and insurers to protect the privacy of PHI and to implement safeguards to prevent unauthorized access or disclosure.

**Home Health Care:** Medical care and support provided in the home to individuals who are unable to leave their home due to illness, injury, or disability. Related terms include: durable medical equipment (DME), home health aides, skilled nursing care. Home health care includes a range of services, from skilled nursing care to physical therapy and home health aide services, and is often covered by Medicare and other insurers.

**Inpatient Prospective Payment System (IPPS):** A payment system used by Medicare to reimburse hospitals for inpatient stays. Related terms include: diagnosis-related groups (DRGs), outpatient prospective payment system (OPPS), payment rates. IPPS is designed to encourage hospitals to provide efficient and effective care, as reimbursement is based on the patient's diagnosis and severity of illness.

**International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM):** A standardized coding system used to describe diagnoses and symptoms for the purpose of billing and reimbursement. Related terms include: CPT, HCPCS, coding. ICD-10-CM includes over 70,000 codes and is used to describe a wide range of medical conditions and symptoms.

**Medicare Administrative Contractor (MAC):** A private company that contracts with the Centers for Medicare and Medicaid Services (CMS) to process Medicare claims and provide provider education and outreach. Related terms include: CMS, Medicare claims processing, provider education. MACs are responsible for ensuring the accuracy and timeliness of Medicare claims processing and for educating providers about Medicare rules and regulations.

**Medically Unlikely Edits (MUEs):** Edits used by Medicare and other payers to identify claims with potentially incorrect coding or billing practices. Related terms include: claim edits, coding errors, billing errors. MUEs are designed to prevent overpayments and to ensure the accuracy and consistency of coding and billing practices.

**Non-covered Services:** Services that are not eligible for reimbursement under a patient's health insurance plan. Related terms include: coverage determination, medical necessity, out-of-pocket costs. Non-covered services may include experimental or investigational procedures, cosmetic surgery, or services that are not considered medically necessary.

**Out-of-Network Providers:** Providers who are not contracted with a patient's health insurance plan. Related terms include: in-network providers, network adequacy, balance billing. Out-of-network providers may charge higher fees than in-network providers, and patients may be responsible for paying the difference between the provider's fee and the amount covered by their insurance plan.

**Outpatient Prospective Payment System (OPPS):** A payment system used by Medicare to reimburse hospitals for outpatient services. Related terms include: APCs, ambulatory payment classification, payment rates. OPPS is designed to encourage hospitals to provide efficient and effective outpatient care, as reimbursement is based on the patient's diagnosis and the complexity of the procedure.

**Payment Bundling:** The practice of combining multiple services or procedures into a single payment. Related terms include: bundled payments, global period, fee-for-service. Payment bundling is designed to encourage providers to coordinate care and reduce unnecessary services, as they are responsible for the total cost of care within the bundled payment period.

**Payment Packing:** The practice of billing for multiple services or procedures at a single encounter, even if they were not actually provided. Related terms include: upcoding, unbundling, fraud. Payment packing is a form of fraudulent