Getting Started with Billing Acronyms

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Medical Billing (also known as RCM- Revenue Cycle Management) uses an alphabet soup of acronyms. Let's start by defining the codes used to build and bill medical claims.

- **AOB** - Assignment of Benefits - document signed by a patient allowing insurance benefits/payment to be sent directly to the provider
- **CARC / RARC-** Claim Adjustment Reason Code / Remittance Advice Remark Code- listed on an EOB/ERA to explain why an insurance payer adjusted a charge on a claim
- **CMS** - Centers for Medicare & Medicaid Services - the federal agency that administers the public health programs of Medicare, Medicaid, the Health Insurance Marketplace, and the Children's Health Insurance Plan (CHIP)
- **CO** - Contractual Obligation - the amount between the amount billed and the amount allowed as listed on an EOB or ERA that is not billable to the patient
- **COB** - Coordination of Benefits - Process by which a patient is covered by 2 or more insurance plans decides who pays in which order
- **CPT** - Current Procedural Terminology - codes used to report medical, surgical, and diagnostic procedures
- **CR** - Corrections and Reversal - code listed on an EOB or ERA explaining an action taken by an insurance payer
- **DME** - Durable Medical Equipment
- **DOS** - Date of Service - the date the office visit and/or procedure took place
- **Dx** - abbreviation for diagnosis
- **EDI** - Electronic Data Interchange - the network that collects information before sending it out to individual insurance providers
- **EIN** - Employer ID number - a 9-digit number assigned by the IRS to identify businesses
- **EFT** - Electronic Funds Transfer - a deposit into a providers bank account by a payer in payment for submitted claims
- **E/M** - Evaluation and Management - part of the CPT code set used to document and bill for a provider's services that involve either the evaluation or managment of a patient's health
- **EOB** - Explanation of Benefits - a statement sent by an insurance payer explaining how a claim was processed
- **ERA** - (also known as an 835 file) - Electronic Remittance Advice - digital file listing how a payer processed a claim. Payments can be posted automatically from this file.
- **HCPCS** - Healthcare Common Procedure Coding System - codes used to report products, supplies, and services not included in the CPT code set

- **HIPAA** - Health Insurance Portability and Accountability Act of 1996. Privacy rule that protects patients from having medical information disclosed to unauthorized people or entities.
- **ICD-10** - International Classification of Diseases, Tenth Edition - codes used to report a patient's diagnosis
- **MA** - Medicare Advantage plan - Medicare part C plan which replaces traditional Medicare coverage
- **NDC** - National Drug Code - a three-segment number used to identify finished, unfinished, and compounded drug products
- **NPI** - National Provider Identifier - a 10-digit code assigned to each provider (can also be assigned as a type 2 organizational NPI) used to identify who provided services to a patient.
- **PA** - Prior Authorization -required by some insurance payers before certain procedures or prescriptions can be provided
- **PHI** - Protected Health Information - information that can be used to identify a patient that is covered under privacy rules, including HIPAA
- **PR** - Patient Responsibility - code listed on an EOB/ERA that designates what amount is the patient's responsibility
- **TIN** - Tax ID number - used by payers to ensure records are kept of who is paid and how much.
- **WC** - Workers' Compensation - a claim due to a work-related injury