

MC BILLING

The Advanced Medical Billing Terminology & Definitions Guide

Essential Terms, Abbreviations, Coding, Claims, Denials, Payments & Revenue Cycle Concepts

BILLING	CLAIMS	DENIALS	WORKFLOWS
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A practical desk reference for medical billers, healthcare administrative staff, students, practice teams, and professionals strengthening their revenue-cycle knowledge.

MC Billing Educational Series | 2026 Edition

Table of Contents

1. Medical Billing Foundations
2. Insurance and Payer Terminology
3. Coding Terminology
4. Claims and Clearinghouse Terminology
5. Professional and Institutional Billing
6. Payment and Reimbursement
7. Denials and Rejections
8. Appeals and Follow-Up
9. Revenue Cycle Management
10. Compliance and Regulatory Terminology
11. Advanced Reimbursement Concepts
12. Common Abbreviations Quick Reference
13. Real-World Billing Scenarios
14. Billing Workflow Quick Reference
15. Study & Onboarding Checklist

How to Use This Guide

Use this e-book as a desk reference, study guide, onboarding resource, or companion to daily billing workflows. The definitions are written in practical language and connect terminology to common revenue-cycle activities.

Important: Payer policies, coding guidance, contracts, and regulations change. Verify current requirements with the applicable authoritative source before acting on a claim. This publication is educational and is not legal, medical, coding, compliance, or reimbursement advice.

1. Medical Billing Foundations

These foundational terms describe the basic language used throughout the healthcare billing lifecycle.

Medical Billing

Definition: The administrative process of submitting healthcare charges to a payer, tracking claims, posting payments, resolving balances, and managing patient responsibility.

Medical Coding

Definition: The process of translating documented diagnoses, services, procedures, and supplies into standardized code sets used for billing and reporting.

Revenue Cycle Management (RCM)

Definition: The financial workflow that begins with patient access and registration and continues through coding, claim submission, payment posting, denial management, and final account resolution.

Accounts Receivable (A/R)

Definition: Money owed to a provider by patients or payers for services already rendered.

Date of Service (DOS)

Definition: The date on which a healthcare service was provided.

Encounter

Definition: A patient interaction or episode of care with a healthcare provider or facility.

Guarantor

Definition: The person or entity financially responsible for a patient's account.

Patient Responsibility

Definition: The portion of an allowed charge assigned to the patient, such as deductible, copayment, coinsurance, or certain non-covered amounts.

Clean Claim

Definition: A claim containing the information needed for processing without known errors or missing required data.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

2. Insurance and Payer Terminology

Insurance terminology helps billers understand coverage, responsibility, and the order in which claims may be processed.

Payer

Definition: An organization responsible for adjudicating and paying eligible healthcare claims.

Subscriber

Definition: The person whose employment, membership, or other eligibility relationship establishes coverage under an insurance plan.

Member ID

Definition: The identifier assigned by an insurer to a covered member.

Group Number

Definition: An identifier associated with an employer or other insurance group plan.

Eligibility Verification

Definition: The process of confirming active coverage and reviewing benefits before or around the time services are provided.

Benefits

Definition: The services, limitations, cost-sharing provisions, and coverage rules included in an insurance plan.

Coordination of Benefits (COB)

Definition: The process used to determine how claims are paid when a patient has more than one health plan.

Primary Payer

Definition: The payer generally responsible for processing a claim first under applicable coordination-of-benefits rules.

Secondary Payer

Definition: A payer that may process remaining eligible amounts after the primary payer adjudicates the claim.

Prior Authorization

Definition: A payer's advance approval requirement for specified services, medications, procedures, or supplies.

Referral

Definition: A direction or authorization from one healthcare professional or payer arrangement to obtain services from another provider, when required.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

3. Coding Terminology

Coding terminology connects clinical documentation with standardized reporting and reimbursement processes.

ICD-10-CM

Definition: The U.S. clinical modification of ICD-10 used to report diagnoses and other health conditions in applicable settings.

CPT

Definition: A standardized code set maintained by the American Medical Association for reporting many medical procedures and professional services.

HCPCS Level II

Definition: A standardized alphanumeric code set used primarily for products, supplies, services, and certain procedures not represented by CPT.

Modifier

Definition: A code appended to a procedure code to provide additional information about how, where, or why a service was performed.

Evaluation and Management (E/M)

Definition: A category of services used to report many patient visits and other encounters involving evaluation and management.

Medical Necessity

Definition: The requirement that a service be appropriate and supported for the patient's condition under applicable payer and program rules.

Bundling

Definition: A payment or coding concept in which multiple services are treated as part of a comprehensive service rather than separately reportable services.

Unbundling

Definition: Separately reporting components of a service when applicable coding rules require them to be reported as a combined or bundled service.

Upcoding

Definition: Reporting a code representing a higher level or more extensive service than is supported by documentation.

Downcoding

Definition: Changing a submitted code to a lower level during review or adjudication when the payer determines that documentation or rules support a lower level.

NCCI

Definition: The National Correct Coding Initiative, a CMS program containing coding edits and related policies intended to promote correct coding.

Global Surgical Package

Definition: A payment concept that may include specified preoperative, intraoperative, and postoperative services within a defined global period.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

4. Claims and Clearinghouse Terminology

These terms explain how claims move from a provider's billing system through electronic submission and payer processing.

Claim

Definition: A request for payment submitted to a health plan for healthcare services or products.

Electronic Claim

Definition: A claim transmitted electronically in a standardized transaction format.

Clearinghouse

Definition: An intermediary that receives, edits, formats, and routes electronic healthcare transactions between providers and payers.

Claim Scrubber

Definition: Software that checks claims for selected errors, missing information, coding conflicts, or payer-specific rules before submission.

Claim Rejection

Definition: A claim that is not accepted for adjudication because of a submission or data problem. A rejection generally occurs before payer adjudication.

Claim Denial

Definition: A payer decision that a submitted claim or line is not payable as billed under the payer's rules.

Corrected Claim

Definition: A claim resubmitted to correct information from a previously submitted claim, when the payer permits correction through that process.

Resubmission

Definition: Submitting a claim again after a rejection, correction, or other issue, using the appropriate payer process.

837

Definition: The standard electronic healthcare claim transaction used for submitting professional, institutional, and certain other claim information.

835

Definition: The standard electronic remittance advice transaction used to communicate payment and adjustment information.

Claim Status

Definition: Information indicating where a claim is in the submission, processing, adjudication, payment, or resolution process.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

5. Professional and Institutional Billing

Professional and institutional claims use different forms, data elements, and billing conventions.

CMS-1500

Definition: The standard paper claim form commonly used for professional services.

UB-04 / CMS-1450

Definition: The standard paper claim form commonly used for institutional services.

NPI

Definition: National Provider Identifier, a unique 10-digit identifier used for covered healthcare providers in standard transactions.

TIN

Definition: Taxpayer Identification Number used for tax and business identification purposes.

Rendering Provider

Definition: The individual provider who performed or supervised the service, when applicable.

Billing Provider

Definition: The provider or entity submitting the claim and generally receiving payment or responsible for billing functions.

Referring Provider

Definition: A provider who directs or refers a patient for services when referral information is applicable.

Place of Service (POS)

Definition: A code identifying the setting in which a professional service was provided.

Type of Bill (TOB)

Definition: A code used on institutional claims to identify the facility, claim type, and related billing information.

Revenue Code

Definition: A code used on institutional claims to identify categories of services or accommodations.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

6. Payment and Reimbursement

Payment terminology helps billers understand how billed charges become payer payments, adjustments, and patient balances.

Allowed Amount

Definition: The amount a payer recognizes for a covered service under its plan or contract rules.

Billed Charge

Definition: The amount submitted by the provider on the claim.

Contractual Adjustment

Definition: The difference between a provider's billed charge and the amount recognized under a payer contract, when applicable.

Deductible

Definition: An amount a member may be required to pay before the health plan begins paying for certain covered services.

Copayment

Definition: A fixed dollar amount a member pays for a covered service, subject to the plan's terms.

Coinsurance

Definition: A percentage of the allowed amount that the member may owe for a covered service.

Write-Off

Definition: An amount removed from the receivable according to contractual, administrative, financial, or other applicable rules.

Explanation of Benefits (EOB)

Definition: A statement explaining how an insurance claim was processed, including charges, allowed amounts, payments, adjustments, and patient responsibility.

Electronic Remittance Advice (ERA)

Definition: An electronic transaction communicating claim payment and adjustment information.

Electronic Funds Transfer (EFT)

Definition: Electronic movement of payment funds from a payer to a provider or financial institution.

Payment Posting

Definition: The process of recording payer and patient payments, adjustments, denials, and related transactions in the billing system.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

7. Denials and Rejections

Knowing the difference between rejection and denial is critical for choosing the correct resolution workflow.

Eligibility Denial

Definition: A denial related to inactive coverage, incorrect member information, or other eligibility issues.

Authorization Denial

Definition: A denial associated with a missing, invalid, or insufficient authorization when authorization was required.

Medical Necessity Denial

Definition: A denial in which the payer determines that the submitted service is not supported as medically necessary under applicable coverage rules.

Timely Filing Denial

Definition: A denial resulting from a claim being submitted after the payer's filing deadline.

Duplicate Claim

Definition: A claim identified as duplicative of another claim or service already submitted or processed.

Non-Covered Service

Definition: A service or item that the applicable plan or program does not cover under its rules.

CARC

Definition: Claim Adjustment Reason Code. Standardized codes used to explain claim-level or service-line financial adjustments.

RARC

Definition: Remittance Advice Remark Code. Standardized supplemental messages that provide additional explanation about a claim adjustment or payment.

Denial Management

Definition: The process of identifying, analyzing, correcting, appealing, preventing, and monitoring claim denials.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

8. Appeals and Follow-Up

These terms describe actions used when a claim needs correction, reconsideration, documentation, or escalation.

Appeal

Definition: A formal request for a payer to reconsider a claim decision.

Reconsideration

Definition: A review of a claim or decision under a payer's defined reconsideration process.

Appeal Letter

Definition: A written explanation supporting a request for reconsideration, generally including the issue, factual basis, documentation, and requested resolution.

Medical Records Request

Definition: A payer request for clinical documentation needed to evaluate a claim or medical necessity.

Peer-to-Peer Review

Definition: A review or discussion involving qualified healthcare professionals, often used in certain medical-necessity or authorization processes.

Escalation

Definition: Moving an unresolved billing or claim issue to a higher-level payer, provider, clearinghouse, or internal resource.

Appeal Deadline

Definition: The date by which an appeal or reconsideration must be received under the applicable payer rules.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

9. Revenue Cycle Management

RCM terminology follows the financial journey from scheduling and registration through final account resolution.

Patient Access

Definition: Front-end activities such as registration, demographic collection, insurance capture, scheduling, and eligibility processes.

Charge Capture

Definition: The process of ensuring that services and billable items provided are accurately recorded for coding and billing.

Charge Entry

Definition: Entering billable services, supplies, and related information into the billing system.

Claim Submission

Definition: The process of transmitting a completed claim to a payer or clearinghouse.

A/R Follow-Up

Definition: Reviewing outstanding receivables and taking appropriate action to resolve unpaid or underpaid accounts.

Days in A/R

Definition: A financial metric estimating the average number of days of revenue held in accounts receivable.

Denial Rate

Definition: A metric expressing the proportion of claims or claim dollars denied under a defined measurement method.

Clean Claim Rate

Definition: A metric measuring the percentage of claims submitted without identified errors or issues under the organization's definition.

Point-of-Service Collection

Definition: Collecting applicable patient responsibility at or near the time services are provided.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

10. Compliance and Regulatory Terminology

Compliance language describes privacy, documentation, oversight, auditing, and improper-payment concepts.

HIPAA

Definition: The Health Insurance Portability and Accountability Act, including federal privacy, security, and transaction-related requirements applicable to covered entities and business associates.

PHI

Definition: Protected Health Information: individually identifiable health information protected under HIPAA when maintained or transmitted in covered contexts.

Minimum Necessary

Definition: A HIPAA principle generally requiring reasonable efforts to limit certain uses, disclosures, and requests of PHI to the minimum necessary for the intended purpose, subject to exceptions.

Fraud

Definition: Knowingly and willfully engaging in deception or misrepresentation for an improper benefit or payment.

Abuse

Definition: Practices that may result in unnecessary costs or improper payments without necessarily involving the intent required for fraud.

False Claims Act

Definition: A federal law addressing certain false or fraudulent claims for government payment.

OIG

Definition: Office of Inspector General within the U.S. Department of Health and Human Services, which conducts oversight and enforcement activities related to federal healthcare programs.

Compliance Program

Definition: An organization's policies, procedures, training, monitoring, and reporting framework designed to promote adherence to applicable laws and requirements.

Audit

Definition: A systematic review of records, processes, claims, coding, payments, or controls for accuracy, compliance, or other defined purposes.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

11. Advanced Reimbursement Concepts

These concepts are useful when working with more complex reimbursement models and payment methodologies.

Fee-for-Service

Definition: A payment model in which providers are paid based on covered services delivered and reported.

Capitation

Definition: A payment arrangement in which a provider or organization receives a fixed per-member payment for defined services over a specified period, subject to contract terms.

Value-Based Care

Definition: A broad term for healthcare payment and delivery approaches that place emphasis on quality, outcomes, efficiency, or other defined performance measures.

Risk Adjustment

Definition: A methodology used to adjust payments or other measures based on differences in patient or population characteristics and expected resource needs.

Bundled Payment

Definition: A payment approach that combines specified services or episodes into a defined payment arrangement.

DRG

Definition: Diagnosis-Related Group. A classification system used in inpatient hospital reimbursement under applicable payment systems.

MS-DRG

Definition: Medicare Severity Diagnosis-Related Group, used in the Medicare inpatient prospective payment system.

APC

Definition: Ambulatory Payment Classification, a classification used in certain outpatient hospital payment methodologies.

RVU

Definition: Relative Value Unit, a component used in certain physician payment methodologies to assign relative resource values to services.

RBRVS

Definition: Resource-Based Relative Value Scale, a methodology used to determine relative values for many physician services.

MIPS

Definition: Merit-based Incentive Payment System, a Medicare clinician payment program within the Quality Payment Program.

Practical Tip: Compare terminology found on claims, remittances, payer portals, and contracts with the current instructions for the specific payer and transaction.

12. Common Abbreviations Quick Reference

Use this section as a fast reference when reading claims, remittances, payer correspondence, and billing reports.

A/R

Definition: Accounts Receivable

AOB

Definition: Assignment of Benefits

CARC

Definition: Claim Adjustment Reason Code

COB

Definition: Coordination of Benefits

CPT

Definition: Current Procedural Terminology

DOS

Definition: Date of Service

EFT

Definition: Electronic Funds Transfer

EOB

Definition: Explanation of Benefits

ERA

Definition: Electronic Remittance Advice

HCPCS

Definition: Healthcare Common Procedure Coding System

HIPAA

Definition: Health Insurance Portability and Accountability Act

ICD-10-CM

Definition: International Classification of Diseases, 10th Revision, Clinical Modification

NPI

Definition: National Provider Identifier

OIG

Definition: Office of Inspector General

PHI

Definition: Protected Health Information

POS

Definition: Place of Service

RARC

Definition: Remittance Advice Remark Code

RCM

Definition: Revenue Cycle Management

TIN

Definition: Taxpayer Identification Number

13. Real-World Billing Scenarios

Eligibility Issue

Coverage appears inactive on the date of service. Verify patient identifiers, coverage dates, and eligibility history; then use the payer's correction, rebilling, or appeal process as appropriate.

Missing Authorization

A service required prior authorization but the claim lacks valid authorization information. Review the authorization record and determine whether the payer permits correction, retroactive review, or appeal.

Timely Filing

A payer denies a claim as late. Review claim submission history, clearinghouse acceptance reports, payer receipt information, contract terms, and any permitted exceptions.

Patient Responsibility

An EOB assigns deductible, copayment, or coinsurance. Post the payer payment and adjustments accurately, then transfer eligible patient responsibility according to the plan and organizational policy.

Underpayment

Payment is lower than expected. Compare the remittance with applicable contract terms or fee schedules, verify coding and modifiers, identify adjustment reasons, and follow the organization's underpayment workflow.

Rejected Claim

A clearinghouse rejects a claim for missing or invalid data. Correct the submission error and resubmit according to the clearinghouse and payer requirements rather than treating the rejection as an adjudicated denial.

14. Billing Workflow Quick Reference

1. Schedule / Register → 2. Verify Eligibility → 3. Obtain Required Authorization → 4. Capture Charges → 5. Code and Review Documentation → 6. Scrub Claim → 7. Submit → 8. Monitor Acceptance → 9. Post Payment/Adjustments → 10. Resolve Rejections/Denials → 11. Follow Up A/R → 12. Bill Eligible Patient Responsibility → 13. Resolve Account

15. Study & Onboarding Checklist

- ☐ Learn common payer and insurance terms.
- ☐ Understand the difference between a rejection and a denial.
- ☐ Learn the basic purpose of ICD-10-CM, CPT, and HCPCS Level II.
- ☐ Practice reading an EOB and ERA.
- ☐ Identify deductible, copayment, coinsurance, and contractual adjustments.
- ☐ Understand primary and secondary billing concepts.
- ☐ Learn organizational timely-filing and appeal workflows.
- ☐ Become familiar with CARC and RARC terminology.
- ☐ Practice tracing a claim from submission through payment or denial.
- ☐ Verify current payer, coding, and compliance requirements before applying a rule.

Resource Disclaimer

This publication is provided for general educational and informational purposes. Medical billing, coding, reimbursement, privacy, and compliance requirements vary by payer, program, contract, jurisdiction, provider type, and service. Users should consult current official guidance, payer policies, contracts, applicable regulations, and qualified professionals when making operational decisions.

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