Glossary

DataLink's healthcare payments glossary includes information about our patent pending services as well as definitions of many healthcare payment related terms.

ACH (Automated Clearinghouse) – A system of the U.S. Federal Reserve Bank that provides electronic funds transfers (EFT) between banks. It is used for all kinds of funds transfer transactions, including the deposit of claim payments from payers to providers. ACH can also be used to accept payments electronically from a patient's bank account to pay their medical bills.

Adjudication – The determination of a member's financial responsibility after a medical claim is applied to the member's insurance benefits.

Consumer Driven Health Plan (CDHP) – CDHP is a system of healthcare that gives individuals more direct control over medical expenses. CDHP is characterized by health plans that offer more affordable premiums while shifting more financial responsibility to the member. Such plans, commonly called high-deductible health plans, typically involve the use of Health Saving Accounts (HSAs). HSAs are personal, interest-bearing and tax-advantaged accounts that the member uses to pay medical expenses.

Claim Status Inquiry – An inquiry to validate and track the status of a claim after it has been submitted to a payer. This is also known as a "276/277".

Claim – A request for payment for services and benefits received. An electronic claim submitted to a payer for payment is known as an "837".

eCheck – An exchange of funds in which money is electronically transferred from the bank account of one party into the bank account of the other party. The checking account routing number and account number are used to draw funds from the account. eChecks can clear much faster than written checks.

Electronic Funds Transfer (EFT) – A common form of funds transfer. It allows providers to electronically deduct funds from a patient's account for services rendered and it allows providers to deposit claim payments from a payer.

Electronic Healthcare Network Accreditation Commission (EHNAC) – Establishes criteria for measuring performance of clearinghouses and value-added networks. InstaMed is accredited by EHNAC for healthcare transactions at the highest level.

Eligibility Verification – An electronic inquiry to obtain information regarding a patient's health insurance benefits. This is commonly referred to as an "Eligibility Benefit Inquiry" or a "270/271".

Explanation of Payment (EOP) – A document or electronic message that contains detailed information regarding how an insurance company or other payer has processed a claim. This is also known as an "835".

Electronic Remittance Advice (ERA) – An electronic version of an Explanation of Payment (EOP).

Flexible Spending Account (FSA) – Allows an employee to set aside a portion of his or her earnings to pay for qualified expenses, most commonly for medical expenses but often for dependent care or other expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in a substantial payroll tax savings.

Health Savings Account (HSA) – A tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a High Deductible Health Plan. The funds contributed to the account and the earned interest are not subject to income tax, but can only be used to pay for qualified medical expenses.

Healthcare Billing & Management Association (HBMA) – A non-profit trade association dedicated to educating and supporting the needs of third-party billing organizations within the healthcare industry.

Healthcare Clearinghouse – Receives information from a healthcare entity and sends it to another healthcare entity. It may process or facilitate the processing of information received in a non-standard format into a standard transaction. It can also receive a standard transaction and process that information into a non-standard format for a receiving entity.

Health Insurance Portability and Accountability Act (HIPAA) – Federal legislation enacted into law in 1996 that covers a broad range of areas within the healthcare industry. Among other things, HIPAA aims to improve the efficiency and effectiveness of healthcare systems by standardizing the electronic exchange of administrative and financial data between healthcare providers, payers and other industry stakeholders. HIPAA also protects the security and privacy of healthcare information, whether stored and transmitted on paper or electronically.

Hospital Information System (HIS) – A comprehensive, integrated information system designed to manage the administrative, financial and clinical aspects of a hospital. This encompasses paper-based information processing as well as data processing machines.

Health Reimbursement Accounts (HRA) – A partially self-funded account in which an employer pays a predetermined portion of medical claims up to a cap.

Optical Character Recognition (OCR) – The mechanical or electronic translation of images of handwritten or typewritten text (usually captured by a scanner) into machine-editable text.

Patient Estimator with Automated Payment – A seamless, automated solution available exclusively to Payer Gatewayplus users that delivers an estimate of a patient's responsibility for co-pays, co-insurance and deductibles specific to the services being provided and specific to the service provider's contract with the patient's health plan. It automates the process of settling authorized funds from any account triggered by an adjudicated claim.

Patient Payment Portal – A web-based service available exclusively to Payer Gatewayplus users that provides a simple, convenient and secure way for patients to pay online with credit, debit, eCheck or the increasingly common varieties of healthcare accounts such as HSA, FSA or HRA.

Payer – An entity that assumes the risk of paying for medical treatments. This can be a self-insured employer, a health plan, an HMO, a PPO or a government agency. Payment is typically made in accordance with a contract between the health plan and the member and/or the health plan and the provider.

PCI Level One – The Payer Gatewayplus portal is certified as a Level One Service Provider with the Payment Card Industry (PCI) Data Security Standard, as well as the VISA Cardholder Information Security Program.

Practice Management System (PMS) – A category of software that deals with the day-to-day operations of a medical practice. Such software frequently allows users to capture patient demographics, schedule appointments, maintain lists of insurance payers, perform billing tasks and generate reports.

Remittance – The funds received as consideration for medical services rendered to a patient. See "Electronic Remittance Advice".

Remote Deposit – The ability to deposit checks into a bank account without having to physically deliver the actual check to the bank by scanning a digital image of a check onto a computer and transmitting that image to the bank.

Swipe Device – A check reader or a device that reads the magnetic strip on the back of cards.

Third Party Administrator (TPA) – An entity that processes healthcare claims and performs related business functions to a health plan.

Workgroup for Electronic Data Interchange (WEDI) – An organization dedicated to improving healthcare through electronic commerce.