# 14 Glossary of Healthcare Terms

## A

**Accreditation:** Health plan accreditation is a rigorous, comprehensive and transparent evaluation process through which the quality of the systems, processes and results that define a health plan are assessed.

**Acute**: A condition that begins suddenly and does not last very long (e.g., broken arm). 'acute" is the opposite of "chronic."

**Acute Care**: Treatment for a short-term or episodic illness or health problem.

**Adequacy**: The extent to which a network offers the appropriate types and numbers of providers in a designated geographic distribution according to the relative availability of such providers in the area and the needs of the plan's members.

**Adjudication**: The process of handling and paying claims. Also see **Claim**.

**Admission Notification**: Hospitals routinely notify Premera of all inpatient admissions that link members to other care coordination programs, such as readmission prevention. The process includes verification of benefits and assesses any need for case management.

**Advance Directives**: Written instructions that describe a member's healthcare decision regarding treatment in the event of a serious medical condition which prevents the member from communicating with his/her physician; also called Living Wills.

**Allied Health Personnel**: Specially trained and licensed (when necessary) healthcare workers other than physicians, optometrists, dentists, chiropractors, podiatrists, and nurses.

**Allowable**: An amount agreed upon by the carrier and the practitioner as payment for covered services.

**Alpha Prefix**: Three characters preceding the subscriber identification number on Blue Cross and/or Blue Shield plan ID cards. The alpha prefix identifies the member's Blue Cross and/or Blue Shield plan or national account and is required for routing claims.

**Ambulatory Patient Group** (APG): A patient (hospital outpatient) classification system designed to explain the amount and type of resources used in an ambulatory visit. Patients in each APG have similar clinical characteristics, and similar resource use and cost. 'Similar resource use' means that the resources used are relatively constant across the patients within each APG. Each patient is not identical but the level of variation in resource use is known and predictable. Developed to differentiate facility (not professional) costs.

**Ambulatory Surgical Center** (ASC): A facility that is certified or licensed as required by the state in which it operates and meets all of the following:

- Has an organized staff of physicians
- Has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgical procedures

- Does not provide inpatient accommodations or services

**Ancillary**: Used to describe additional services that are related to care, such as home based services, CAM/Chiro, physical therapy, speech therapy, occupational therapy, Kidney Centers, Skilled Nursing Facilities, and lab work.

**Ancillary Charge**: The fee associated with additional service performed prior to and/or secondary to a significant procedure, such as lab work, x-ray, and anesthesia.

**Appeal**: A formal request by a member, physician or provider for reconsideration of a decision, such as a utilization review recommendation, a benefit payment or an administrative action, with the goal of finding a mutually acceptable solution. Also see **Complaint**.

**Approved Facility or Program**: A facility or program that is licensed, certified, or otherwise authorized pursuant to state or federal law to provide healthcare and is approved by a health plan to provide the care described in a contract.

**Arbitration**: A process in which the parties to a dispute submit their dispute to an impartial third party for a final, binding decision.

**Authorization**: A determination by Care Management (usually before a service occurs) that the service meets medical necessity criteria, and that the member has eligibility and benefits under his/her plan.

**Average Wholesale Price (**AWP): Commonly referred to as AWP. The standardized cost of a pharmaceutical charged to a pharmacy provider by a large group of pharmaceutical wholesale suppliers.

## B

**bcbs.com**: The BCBS Association's website that contains useful information for providers about BlueCard.

**Balance Billing**: Billing a member for charges above the "allowable charge" paid by the health plan (i.e., the difference between billed charges and the plan's allowable). Contracted providers are prohibited from balance billing for Medically Necessary Covered Services.

**Behavioral Healthcare**: The assessment and treatment of mental and/or psychoactive substance abuse disorders.

**Benefit Advisory**: Available to physicians and providers "on request" when a coverage determination is subject to medical necessity, and a member contract does not require preauthorization or authorization. A determination by Care Management (usually before a service occurs) that the service meets medical necessity criteria and that the member's plan has this type of benefit available (not a guarantee of payment). Payment is subject to the member's benefits and eligibility at the time of service, provided that the member has not exceeded his/her plan's maximum benefits.

**Benefit Booklet**: A document prepared by a health plan for its members that describes benefits, services, limitations and exclusions of coverage.

**Benefit Level**: The limit or degree of payment for services a member is entitled to receive based on the subscriber contract with a health plan or insurer.

**Billed Claims**: The fees or costs for healthcare services provided to a member and submitted to the plan or an intermediary by a physician or healthcare practitioner.

**BlueCard®**: A Blue Cross and Blue Shield Association program that allows traditional, PPO, Point-of-Service and HMO members who live and travel outside of their plan's service area to obtain healthcare from Participating practitioners.

**BlueCard® *Access*®**: A toll-free number (800-810-BLUE) to help clinics and members locate healthcare providers in another BCBS plan's area. This number is useful when referring a patient to a physician, provider or healthcare facility in another location. It can also be accessed through its website at: bcbs.com/healthtravel/finder.html.

**BlueCard® *Eligibility*®**: A toll-free number (800-676-BLUE) for clinics to verify membership and coverage information on patients from other BCBS plans.

**BlueCard® PPO**: A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

**BlueCard PPO Member**: An individual who carries an ID card with this identifier on it. Only members with this identifier can access the benefits of BlueCard PPO.


**BlueCard Doctor & Hospital Finder Website**: bcbs.com/healthtravel/finder.html. This website allows you to locate healthcare providers in another Blue Cross and/or Blue Shield plan's area. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you, as a provider, is incorrect on the website, please contact Premera.

**BlueCard Worldwide®**: A program that allows BC or BS members traveling or living abroad to receive nearly cashless access to covered inpatient hospital care, as well as access to outpatient hospital care and professional services from healthcare providers worldwide. The program also allows members of foreign BC or BS plans to access domestic (U.S.) BC or BS provider networks.

**Board Certified**: A physician who has passed an examination given by a medical specialty board and has been certified as a specialist in that medical area.

**Board Eligible**: A physician who is eligible to take the specialty board examination by virtue of having graduated from an approved medical school, completed a specific type and length of training, and practiced for a specified period of time.

## C

**CMS-1500 Form**: A universal claims billing form used by physicians and other healthcare practitioners to bill payers for professional services (formerly called HCFA-1500 form).

**Calendar Year**: The period of time from January 1 of any year through December 31 of the same year, inclusive. Used often in connection to deductible amount provisions in major medical plans.

**Care Coordination**: Coordination of a member's care from pre-certification through hospitalization and/or discharge to an alternative setting. Care coordination includes the functions of concurrent review, discharge planning, pre-admission screening and re-admission

prevention.

**Care Management**: Programs designed to provide coordination of care for members through a variety of activities including (but not limited to) Preadmission Screening, Readmission Prevention, Case Management, Prospective and Retrospective Review.

**Case Management**: Coordination of care for members with complex, catastrophic and usually high-cost medical conditions. Includes the process of reviewing and developing treatment plans with the input of the member, physician and ancillary providers to ensure that the member receives services in the appropriate setting with no compromise of quality.

**Case Manager**: An experienced professional (e.g., nurse, doctor, or social worker) who works with members, physicians, providers and insurers to coordinate all services identified in the case or disease management care plan.

**Centers for Medicare and Medicaid Services**: CMS is the federal agency responsible for administering Medicare and overseeing states' administration of Medicaid (formerly called Healthcare Financing Administration or HCFA).

**Certificate of Coverage**: A description of the benefits included in a carrier's plan. State laws require the certificate of coverage, which represents the coverage provided under the contract issued to the employer. The certificate is provided to the employee.

**Chronic Condition**: Impaired health status or medical condition that recurs or persists over a long period of time as opposed to an acute or emergent condition.

**Claim**: Information submitted by a physician, provider or member to establish that medical services were provided to a member, from which the claim is processed for payment. Also see **Adjudication.**

**Clean Claim**: A claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim.

**Clinical Practice Guidelines**: To promote the highest clinical performance, clinical practice guidelines are provided to physicians as a reference to enhance the efficiency and effectiveness of their patients' care and services.

**Co-insurance**: The portion of covered healthcare costs paid by the member, usually according to a fixed percentage. Co-insurance often applies after first meeting a deductible requirement.

**Complaint**: An expression of dissatisfaction by a member or practitioner. Complaints can be given orally or in writing. Also see **Appeal**.

**Concurrent Drug Evaluation**: An electronic assessment of claims at the point-of-service (i.e., pharmacy) to detect potential problems that should be addressed prior to dispensing drugs to patients.

**Concurrent Review**: An assessment process that proactively identifies institutionalized FEP health plan members. The process involves reviewing clinical information, establishing a suitable level of medical care within the appropriate setting and determining outpatient health needs upon discharge.

**Consolidated Omnibus Budget Reconciliation Act**: Commonly called COBRA, this federal act requires a group health plan to allow employees and certain dependents to continue their group coverage for a stated period of time following a qualifying event that causes them to lose group health coverage (e.g., reduced work hours, death or divorce of a covered employee, and termination of employment).

**Contract Year**: The period of time from the effective date of the contract to the expiration date of the contract.

**Conversion Factor**: The dollar amount that, when multiplied by Relative Value Schedule unit values, creates the payment for the service. The unit values vary by medical procedure according to the relative complexity (cost) of the different procedures.

**Coordination of Benefits** (COB): A contract provision that ensures that members receive full benefits and prevents double payment for services when a member has coverage from more than one health plan. Requires that all programs coordinate benefit payment to eliminate over-insurance or duplication of coverage. COB ensures that the total benefits allowed by all carriers do not exceed the eligible charges. Provision also describes the order for multiple carriers to pay benefits.

**Copayment** (or Copay): A cost-sharing arrangement in which a member pays for a specific service (e.g., $15 for an office visit) when service is rendered. A typical copay is a fixed amount for an office visit, prescription or hospital service.

**Cost Sharing**: A general set of financing arrangements via deductibles, copays and/or co-insurance in which a member pays some of the costs to receive care. Also see **Copayment, Co-insurance** and **Deductible**.
**Coverage**: The type of benefits provided through a healthcare contract. There are various benefit levels, such as basic or major medical.

**Covered Person**: An individual who meets eligibility requirements and for whom premium payments are paid for specified benefits of the contractual benefits agreement.

**Covered Services**: Medically necessary medical and hospital services, supplies and accommodations for which a member is eligible under the terms of the applicable Subscriber Agreement.

**CPT**: See **Current Procedural Terminology**.

**Credentialing**: The process by which an organization authorizes, contracts or employs practitioners who are licensed, certified or registered to practice independently to provide services on behalf of the organization. Applicants are eligible when they meet established standards/requirements such as education, licensure, professional standing, services, accessibility, utilization, and quality.

**Current Procedural Terminology** (CPT): A healthcare industry standard for the reporting of healthcare procedures and services. A system of terminology and coding developed by the AMA. Used to describe coding and reporting of medical services and procedures performed by physicians or providers. Each service/procedure is identified by its own unique five-digit code.

**Custodial Care**: Care furnished for the purpose of meeting personal needs that could be

provided by persons without medical training or professional skills. Any portion of a service, procedure or supply provided primarily:

- For ongoing maintenance of a member's health and not for its therapeutic value in the treatment of an illness or injury
- To assist a member in meeting the activities of daily living (e.g., help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication) that do not require constant attention of trained medical personnel.

**Customer Service**: An administrative department designed to provide benefit, eligibility, claim adjudication and payment information to members, practitioners and facilities.

## D

**Date of Service**: The date on which a member received healthcare services.

**Deductible**: A predetermined amount of eligible expense, designated by the subscriber's policy, that a member must pay each year from his/her own pocket before the plan will make payment for eligible benefits.

**Dependent**: An individual who relies on a member for support or obtains health coverage through a spouse, parent or grandparent who is a member.

**Diagnosis**: The identification of a disease or condition through analysis and examination.

**Diagnosis Related Group** (DRG): A system used by Medicare to classify inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, gender and complications.

**Disability**: A condition that results in functional limitations that interferes with a member's ability to perform his/her customary work and results in substantial limitation of one or more major life activity.

**Discharge Planning**: The comprehensive evaluation of a member's medical needs in order to arrange for appropriate care after discharge from an inpatient setting. Process of developing a care regimen for a patient leaving institutional clinical care, including appropriate timing and follow-up examinations and treatment.

**Disease**: An interruption, cessation or disorder of body or mental functions, systems or organs.

**Disease Management**: Condition-specific programs designed to facilitate clinical outcomes, develop provider and member satisfaction and contain medical cost trends for Premera members with chronic illness.

**Drug Formulary** (Preferred Drug List): A listing of prescription medications that are used by the health plan and will be dispensed through participating pharmacies to members. A plan that has adopted an "open or voluntary" formulary allows coverage for both formulary (preferred) and non-formulary (non-preferred) medications. A plan that has adopted a "closed, select or mandatory" formulary limits coverage to those drugs on the formulary.

**Durable Medical Equipment** (DME): Equipment that can be used repeatedly and is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury and is appropriate for use at home (e.g., hospital beds, wheelchairs and oxygen equipment). See Home Medical Equipment (HME).

## E

**Effective Date**: The date a contract becomes enforceable for a specific member or group.

**Electronic Data Inter-change**: The computer-to-computer exchange of business or other information between two organizations (trading partners). The data may be in either a standardized or proprietary format. Also known as EDI.

**Electronic Medical Record**: EMR is a computerized record of a patient's clinical, demographic, and administrative data. Also known as a computer-based patient record.

**Eligibility**: Rules governing access to coverage for an insurance program. Medicare eligibility is based upon citizenship and age; Medicaid depends on state enrollment in Aid to Families with Dependent Children (AFDC), Social Security Income (SSI), or other criteria. Eligibility for group enrollment can vary.

**Eligibility Date**: The defined date a member becomes eligible for benefits under an existing contract (see **Effective Date**).

**Eligible Dependent**: A dependent of a member who meets the requirements specified in the group contract to qualify for coverage and for whom premium payment is made.

**Eligible Employee or Person**: One who meets the requirements specified in the contract to qualify for coverage. Requirements might include length of time worked for an employer or number of hours worked.

**Employee Assistance Program** (EAP): Services designed to assist employees, family members and employers in finding solutions for workplace and personal problems. Services can include assistance for family or marital concerns, legal or financial problems, elder care, child care, substance abuse, emotional stress issues and daily living concerns. EAPs may address violence in the workplace, troubled employees, sexual harassment, transition or events that increase the rate of absenteeism or employee turnover, lower productivity and other issues that impact an employer's financial success or employee relations management. EAPs also can provide voluntary or mandatory access to behavioral health benefits through an integrated behavioral health program.

**Employer Contribution**: The amount an employer contributes toward the premium cost of a healthcare contract.

**Encounter**: A face-to-face meeting between a member and a healthcare practitioner where services are provided.

**Enrolled Group**: Persons with the same employer or with membership in a common organization who are enrolled in a health plan. Usually, there are stipulations regarding the minimum size of the group and the minimum percentage of the group that must enroll before the coverage is available. (Synonym: Contract Group)

**Enrollee**: An individual enrolled for coverage under a health plan benefit contract and eligible on his/her own behalf (not by virtue of being an eligible dependent) to receive the healthcare services provided under the contract. Also see **Member**.

**Evidence of Coverage**: A document given to the member that contains an explanation of benefits and services available under the member's plan and outlines the rights and responsibilities of the plan.

**Exclusions**: Specific circumstances or conditions listed in the contract or employee benefit plan for which the policy or plan will not provide benefit payments.

**Experimental, Investigational Services**: Any service (including a facility, procedure, treatment, equipment, drug, drug usage, medical device or supply) that, as determined by the carrier, meets one or more of the following criteria:

- A drug or device that cannot be lawfully marketed without the approval of the United States Food and Drug Administration (FDA) and has not been granted such approval on the date it is furnished.
- The facility or practitioner has not demonstrated proficiency in the service based on volume of cases, experience or outcome.
- Reliable evidence shows the service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Reliable evidence shows the service is not as safe and effective for a particular medical condition as compared to other generally available services, and it poses a significant risk to the member's health or safety.
- Reliable evidence means published reports and articles in authoritative medical and scientific literature, scientific results of the practitioner of care's written protocols, or scientific data from another practitioner studying the same service.

**Explanation of Benefits** (EOB): A statement sent to members by their health plan that lists services provided, amounts billed and payments. An EOB is not a bill.

**Explanation of Payment** (EOP): The statement sent to physician and provider offices by the health plan that lists services provided, amounts billed and payments.

**Extended Care Facility**: A nursing home or nursing center licensed to operate in accordance with all applicable state and local laws to provide 24-hour nursing care. Such a facility may offer skilled, intermediate or custodial care, or any combination of these levels of care. Also see **Skilled Nursing Facility** and **Custodial Care**.

## F

**Facility Provider**: An organization or facility that provides healthcare services, such as hospitals, home-health agencies, skilled nursing facilities, nursing homes and surgical centers. Providers are healthcare facilities contracted with Premera to provide covered healthcare services to members. Also see **Practitioner**.

**Fee-for-Service** (FFS): A long-standing, healthcare payment system under which practitioners receive a fixed payment for each visit or service provided.

**Flat Fee Days**: The period of time established for all care provided by a surgeon for an individual surgical procedure that is included in the total surgical fee.

**Free-Standing Outpatient Surgical Center**: A healthcare facility, physically separate from a hospital, that provides pre-scheduled, outpatient surgical services. Also called a Surgi-center.

**Frequency**: The number of times a service is provided.

## G

**Generic Drug Equivalent**: chemically equivalent copy of a brand name drug for which the patent has expired. A generic version is typically less expensive and sold under a common or "generic" name for that drug (e.g., Valium is the brand name for a tranquilizer, which is also available under its generic name of Diazepam). Also see **Generic Substitution**.

**Generic Substitution**: Dispensing a generic drug in place of a brand name medication. Substitution guidelines are defined by state regulations. Also see **Generic Drug Equivalent**.

**Grandfathering**: An outcome of the Patient Protection and Affordable Care Act. Maintaining "grandfathered" status is the specific process for allowing members to keep their pre-healthcare reform plans.

**Group**: A collection of individuals eligible for group coverage by virtue of a common attribute such as employment or membership in a union, association or organization. A group is treated as a single entity as typically an employer has purchased medical coverage on behalf of its full-time employees.

**Group Contract**: A contract signed by both the plan and the enrolling group that constitutes the agreement regarding the benefits, exclusions and other conditions between the entities. A group contract is also known as, the agreement with persons who obtain coverage for themselves or for themselves and their children, whether under a group or individual program.

## H

**Healthcare Facility**: An institution that provides services to members. Examples include a hospital, hospice, skilled nursing facility, or ambulatory surgical center. A healthcare facility may also be referred to as a "provider."

**Health Coverage**: Protection that provides payment of benefits for covered sickness or injury. This may include short and long-term disability, dental, medical and vision care, and, sometimes, accidental death coverage as well as other benefits.

**Health Insurance Portability & Accountability Act** (HIPAA): A federal law that outlines the requirements that employer-sponsored group insurance plans, insurance companies and managed-care organizations must satisfy to provide health insurance coverage in the individual and group healthcare markets.

**Health Plan**: Health maintenance organization, preferred provider organization, insured plan, self-funded plan or other entity that covers healthcare services. Also see **Plan**.

**Health Plan Employer Data & Information Set**: Standardized set of performance measures to assist employers and other healthcare purchasers in understanding and comparing the value of these purchases and evaluating the health plan's performance. Also called HEDIS®.

**Hold Harmless**: An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed on with the plan as full payment for these services.

**Home-health Agency**: A facility or program licensed, certified or otherwise authorized pursuant to state and federal laws to provide healthcare services in the home.

**Home Medical Equipment** (HME): Equipment and medical supplies used in the home that can be used repeatedly and is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury (e.g., hospital beds, wheelchairs and oxygen equipment). See called Durable Medical Equipment (DME).

**Hospice**: A facility or program engaged in providing palliative and supportive care of the terminally ill. They are licensed, certified or otherwise authorized pursuant to the law of jurisdiction where services are provided.

**Hospital**: A facility legally operating as a hospital that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured or ill persons by or under the supervision of a staff of physicians
- It provides 24-hour nursing services by or under the supervision of registered nurses
- In no event will a "hospital" be an institution that is run mainly:
  - As a rest, nursing or convalescent home, residential treatment center or health resort
  - To provide hospice care for terminally ill patients
  - For the care of the elderly
  - For treatment of chemical dependency or tuberculosis

**Hospital-Based Physician**: A physician who functions as an integral part of the hospital's purpose and sees patients within a hospital department (e.g. radiologists, anesthesiologists, pathologists, etc.).

## I

**ICD-9CM**: The International Classification of Diseases, 9th Revision, Clinical Modification. A listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide reliable, consistent communication on claim forms. Designed for the classification of morbidity and mortality information for statistical purposes, for the indexing of hospital records by disease and operation, and for data storage and retrieval.

**ICD-10:** Replaces ICD-9 and will be required in the U.S. on all HIPAA transactions by Oct. 1, 2013 for both reporting and payment of claims.

**Identification Number**: The number appearing on the member's ID card identifying the plan and the member. This number must be used on all claims and inquiries.

**Indemnity**: An insurance program, not offered by healthcare service contractors (e.g. Premera Blue Cross or Premera Blue Cross Blue Shield of Alaska), in which the insured members are reimbursed for covered expenses.

**Inpatient**: A member who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours.

**Inpatient Services**: Medical and surgical services and supplies furnished to a member admitted to a healthcare facility as an inpatient.

**Integrated Health Management**: A department that encompasses Care Management, Quality, Disease Management, Medical Services and Clinical Contract Management (previously known as Care Facilitation).

## L

**Length of Stay** (LOS): Number of days that a member stayed in an inpatient facility.

**Line of Business (**LOB): Different product lines or plans offered by an insurance carrier (e.g., traditional, PPO, managed care, Medicaid, Medicare) as options to its members.

***Locum Tenens* Physician**: A substitute physician who temporarily replaces a contracted physician for a specified period of time while the physician is absent from his/her practice. Premera retains the right to refuse a particular *locum tenens* physician based on credentialing requirements. If a *locum tenens* physician will provide services for 90 days (either full-time or part-time) or longer, he/she must be credentialed.

**Long-term Care**: Assistance and care for persons with chronic disabilities. The goal of long-term care is to help people with disabilities be as independent as possible. It is focused more on caring than on curing. Long-term care assists members who require help with the activities of daily living (ADLs) or who suffer from cognitive impairment.

## M

**Medicaid**: A federal program administered and operated individually by participating state and territorial governments. It provides medical benefits to eligible low-income persons needing healthcare.

**Medical Director**: A physician employed by the plan to assist in judgments on nonstandard claims issues.

**Medical Emergency**: The urgent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, especially if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the member's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

Examples:

*Medical emergency:* severe pain, suspected heart attack and fracture.
*Non-medical emergency*: minor cuts and scrapes.

**Medical Necessity**: The evaluation of healthcare services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with medical practice guidelines regarding type, frequency and duration of treatment. Also see **Medically Necessary**.

**Medical Policy**: A guide to evaluate the medical necessity of a particular service or treatment.

**Medical Record**: The physician or provider's record in which clinical information related to physical, social and mental health services is recorded and stored.

**Medical Supplies**: Items which, due to it therapeutic or diagnostic characteristics, are medically necessary to carry out the care that a physician ordered for treatment of the member's illness or injury (i.e., catheters, syringes, surgical dressings, irrigating solutions, intravenous fluids, etc.).

**Medically Necessary**: Those covered services and supplies that are determined to meet all of the following requirements. They must be:

- Essential to the diagnosis or the treatment of an illness, accidental injury or condition harmful or threatening to the member's life or health, unless provided for preventive services when specified as covered
- Appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature
- Medically effective treatment of the diagnosis as demonstrated by the following:
  - Sufficient evidence exists to draw conclusions about the effect of the health intervention on health outcome

  - Evidence demonstrates that the health intervention can be expected to produce its intended effects on health outcomes
  - Expected beneficial effects of the health intervention on health outcomes outweigh its expected harmful effects
- Cost-effective as determined by being the least costly of the alternative supplies or levels of service that is medically effective and can safely be provided to the member. A health intervention is cost-effective if there is no other available intervention that offers a clinically appropriate benefit at a lower cost
- Not primarily for research or data accumulation
- Not primarily for the convenience of a member, a member's family, a member's physician, or another practitioner.

Also see **Medical Necessity**.

**Medicare**: Established under Title XVIII of the Social Security Act. A nationwide, federally funded and administered health insurance program that covers the costs of hospitalization, medical care and some related services for individuals who qualify under the Social Security Act. Medicare has two parts:

- *Part A* - Hospital Insurance. Covers inpatient costs and post-hospital care in the member's home or in an extended-care facility; covers pharmaceuticals provided in hospitals, but not those provided in outpatient settings. Also called Supplementary Medical Insurance Program.
- *Part B* - An elective program. Covers the cost of outpatient services.

**Medicare Crossover**: The crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

**Medicare Supplemental**: Pays for expenses not covered by Medicare (also known as Medigap).

**Member**: Participants in a health plan (subscriber/enrollee and/or eligible dependent) who make up the plan's enrollment and are eligible to receive covered benefits. Also see **Enrollee**.

## N

**National Account**: An employer group with offices or branches in more than one geographic location with a benefit program designed to provide uniform coverage to all its employees.

**National Practitioner Data Bank** (NPDB): The Data Bank collects and releases to eligible parties the following information as it relates to the professional competence and professional conduct of physicians, dentists and, in some cases, other licensed healthcare practitioners:

- Medical malpractice payments resulting from a written claim or judgment
- Adverse license actions taken by State Medical and Dental Boards
- Professional review actions taken by hospitals and other healthcare entities that adversely affect clinical privileges for a period longer than 30 days; or voluntary surrender or restriction of clinical privileges by a physician or dentist while under, or in return for not conducting, an investigation relating to possible incompetence or improper professional conduct
- Professional review actions taken by professional societies that adversely affect society memberships.

**Network**: An array of varied physicians and provider types within the plan's service area that render covered healthcare services to the plan's members.

**Non-covered Services**: Services not covered by a member's Subscriber Agreement and for which the plan does not provide benefits. Non-covered services are identified as such on participant's payment voucher and the member's explanation of benefits.

**Non-Participating** (Non-Par): A term used to describe a physician or other provider who is not contracted with the carrier or health plan. Members receive the highest level of coverage when they see Participating physicians and providers.

## O

**Occupational Therapy**: Treatment or training of the physically or emotionally impaired to prevent disability, evaluate behavior, and restore disabled persons to health, social, or economic independence by use of work related skills under the supervision of a registered therapist.

**Office Visit**: Healthcare services rendered by a practitioner in an office setting.

**Open Enrollment Period**: A time when members in a health benefit program have an opportunity to re-enroll or select an alternate health plan offered to them, usually without evidence of insurability or waiting periods.

**Optical Character Recognition** (OCR): A scanner that mechanically "reads" printed paper claims. Unlike scanners that only photocopy information; an OCR scanner digitizes the claim form to permit the submitted information to be entered directly into the claims processing system. OCR capabilities accelerate the claims adjudication process.

**Other Party Liability** (OPL): A cost containment program that recovers money where primary responsibility does not exist because of another group health plan or contractual exclusions. Includes coordination of benefits, workers' compensation, subrogation, and no-fault auto insurance.

**Out-of-area**: Coverage for treatment obtained by a covered person outside plan's service area.

**Out-of-network**: Those physicians or other providers who are "out-of-network" because they have not signed a contract with the plan and/or are out of the plan's service area. Members receive the highest level of benefits when they receive care "in-network."

**Out-of-pocket Limit**: The total payments toward eligible expenses that a member funds for him/herself and/or dependents (e.g., deductibles, copays and co-insurance). Once this limit is reached, benefits will usually increase to 100 percent for health services received during the rest of that calendar year. Some out-of-pocket costs (i.e., cosmetic surgery) are not eligible for out-of-pocket limits.

**Outpatient**: A person who receives healthcare services without being admitted to a hospital.

**Outpatient Services**: Services provided to a member who is not bedridden and does not require overnight hospitalization.

**Outpatient Surgery**: One day or same-day surgery without anticipation of the overnight stay of a member. (Synonyms: Ambulatory Surgery, Day Surgery)

**Over-the-counter Drug**: Commonly called OTC. A retail drug product that does not require a prescription under federal or state law.

**P**

**Paid Claim**: The amounts paid to a practitioner, provider or member to satisfy the contractual liability of the health plan. The amount does not include any member liability for ineligible charges or for deductibles or copays.

**Participating** (PAR) **Facility**: A facility that has completed the credentialing process and signed a contract with the health plan to deliver medical services to members. A facility may be a skilled nursing facility, hospital, pharmacy, nursing home, home-health agency or surgical center that has contractually accepted the health plan's terms and conditions.

**Participating** (PAR): A physician or other healthcare practitioner who has completed the credentialing process and signed a contract with the health plan to deliver medical services to members. Also see **Non-participating**.

**Payment Policy:** Payment Policy is used to determine reimbursement when providers bill for more than one service for the same member on the same date. The member's eligibility and the provider's fee schedule are applied prior to application of the payment policy. Note: Payment Policy addresses billing and provider payment rules while Medical Policy addresses appropriateness of treatment.

**Patient Protection and Affordable Care Act (PPACA):** A federal statute that was passed by Congress and was signed into law by President Barack Obama on March 23, 2010. The law (along with the Health Care and Education Reconciliation Act of 2010) is the principal healthcare reform legislative action of the United States Congress (also known as ACA (Accountable Care Act).

**Peer Review**: Evaluation of review of the performance of colleagues by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician's practice by another physician). The term is used for both utilization management and quality assurance activities.

**Peer Review Organization** (PRO): An entity established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, re-admissions and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates, and reducing lengths of stay while ensuring against inadequate treatment. Also known as professional standards review organization.

***Per Diem* Rate**: Fixed rate set in advance to cover hospital or other inpatient institutional costs for one day of care.

**Pharmacy & Therapeutic** (P&T) **Committee**: Organized panel of physicians from varying specialties who function as an advisory panel to Premera regarding the safe and effective use of prescription medications. Often comprises the official organizational line of communication between the medical and pharmacy components of the health plan. A major function of such a committee is to develop, manage and administer a drug formulary.

**Physical Therapy**: Treatment concerned with restoration of function and the prevention of disability following disease, injury or loss of body parts under the supervision of a registered physical therapist.

**Physician**: A Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is duly licensed and qualified under the law of jurisdiction in which treatment is received, or as defined in the

summary plan description.

**Physician Assistant** (PA): Licensed graduate of an accredited two-year training program who provides medical care under the guidance and direct supervision of a physician.

**Plan**: A healthcare services contractor, health maintenance organization, insurer, trust, self-funded health program or other entity responsible for the payment of Covered Services rendered to Enrollees. See **Health Plan**

**Preadmission Screening**: A review of scheduled admissions by Care Management. Generally conducted before a patient is admitted to proactively identify post-hospital resource requirements. The review may identify the need for other Integrated Health Management programs, such as case management and/or contacting the physician and member to optimize the member's care, or otherwise assist in arranging a solution.
**Pre-authorization**: See **Authorization**.

**Pre-certification:** The formal process of obtaining certification or authorization for healthcare services. Often involves appropriateness review against criteria and assignment of length of stay for inpatient care.

**Pre-determination**: A benefit quote by Customer Service usually before a service occurs to advise whether the service is a covered benefit under the member's health plan. It does not include a review for medical necessity and is not a guarantee of payment. Also see **Benefit Advisory**.

**Practitioner**: An individual (e.g., MD, DO, ARNP, therapist) who provides professional healthcare services to members and is licensed, certified or registered by the state in which the services are performed.

**Pre-existing Condition**: Any medical condition that was diagnosed or treated within the period immediately preceding the member's effective date of coverage under the healthcare contract. Any known or unknown condition for which a medical diagnosis has been made, treatment has been received within a specified period of time immediately prior to enrollment, or which would have caused a prudent person to seek medical diagnosis or treatment.

**Preferred**: Physicians, healthcare practitioners and facilities that have contracted with Premera to provide health services to its members.

**Preferred Provider Organization** (PPO): A plan in which agreements are established with "Preferred" practitioners and providers for a discount of services. Usually, PPO plan enrollees achieve higher benefit levels and lower costs when they obtain care within the PPO network of practitioners and providers, thus encouraging members to use Preferred practitioners and providers. Members are generally allowed benefits for non-participating practitioner or provider services, usually with significant copayments.

**Premium**: The amount paid to a carrier for providing coverage under a contract. Premiums are typically set in coverage classifications such as:

- Individual, two-party and family
- Employee and dependent unit
- Employee only, employee and spouse, employee and child, and employee, spouse and child.

**Prescription Medication**: A drug that has been approved by the Food and Drug Administration

and can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician. Also see **Over-the-counter Drug**.

**Preventive Care**: Comprehensive care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination, immunization and well person care.

**Primary Coverage**: Under coordination of benefit rules, the coverage plan that considers and pays its eligible expenses without consideration of any other coverage.

**Principal Diagnosis**: After examination, the condition established to be mainly responsible for the patient seeking healthcare services from a practitioner. Commonly refers to the condition most responsible for a member's admission to the hospital.

**Prospective Review**: Review of requested services by Care Management before the service occurs for determination of medical necessity, benefits and eligibility (e.g., authorization, benefit and pre-admission screening).

**Protected Personal Information** (PPI): Any and all information created or received by the company that identifies or can readily be associated with the identity of an individual, whether oral or recorded in any form or medium, that directly relates to the:

1. Past, present or future physical, mental or behavioral health or condition of an individual
2. Past, present or future payment for the provision of healthcare to an individual
3. Provision of healthcare to an individual; and past, present or future finances of an individual, including, without limitation, an individual's name, address, telephone number, subscriber number or wage information.

**Provider**: A healthcare practitioner or facility that is duly licensed, certified or registered by the state in which services are performed.

## Q

**Quality Improvement**: A formal set of activities to assess and improve the level of performance of key processes and outcomes within Premera. Opportunities to improve care and service are found primarily by examining the systems and processes by which care and services are provided (both internally and within medical groups).

**Quality of Care**: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

## R

**Readmission Prevention**: An after-hospital-discharge follow-up of members by Care Management to identify any post-hospital needs to facilitate recovery, prevent hospital re-admission and identify potential case management interventions.

**Referral**: A process initiated by a PCP to refer a managed care patient for specialty care or a hospital service.

**Rehabilitation Therapy**: A combination of various therapies to restore or improve a bodily function that was lost or impaired as a direct result of a covered illness, disease or injury.

**Relative Value Scale**: Relative Value Scale (RVS) is a method of determining benefits based on establishing unit values as norms for various medical and surgical procedures through value rating of each procedure to others by using a conversion factor to arrive at a dollar value for

benefits. Also see **Resource Based Relative Value Scale** (RBRVS).

**Routine Business Function**: Any activity undertaken by the company, or by a business associate on behalf of the company, in the ordinary course of health plan business for the purpose of:

1. Carrying out the management functions of the company, including, but not limited to, underwriting, actuarial, care management, case management, disease management and quality reviews
2. Obtaining subscription charges; and
3. Determining or fulfilling responsibility for coverage under the health plan and for the provision of benefits under the health plan, including, but not limited to, member benefit eligibility, payment of member claims, customer service, coordination of member benefits with other insurance carriers or liable third parties.

**Retrospective Review**: Review of identified services by Care Management after the service has been billed. Reviews include, but are not limited to, determination of medical necessity, benefit clarifications, appropriate application of benefits, pricing and coding questions, appeals and utilization management.

## S

**Second Opinion**: An opinion obtained from an additional healthcare professional prior to the performance of a medical service or a surgical procedure. May relate to a formalized process, either voluntary or mandatory, that is used to help educate a member regarding treatment alternative and/or to determine medical necessity.

**Secondary Coverage**: The plan that has the responsibility for payment of eligible charges not covered by the primary coverage. Also see **Primary Coverage** and **Coordination of Benefits**.

**Service Area**: The geographic area serviced by the health plan as approved by state regulatory agencies and/or as detailed in the certificate of authority.

**Skilled Care**: Care ordered by a physician that requires the medical knowledge and technical training of a licensed healthcare professional (e.g., registered nurse, etc).

**Skilled Nursing Facility** (SNF): An inpatient facility (either free-standing or part of a hospital) that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in a hospital. A SNF does not include a convalescent nursing home, rest facility or facility for the aged that primarily furnishes custodial care. Also see **Extended Care Facility**.

**Subrogation**: The right to recover money paid for services when determined that another party is legally responsible for payment of expenses. A procedure in which an insurance company recovers from third parties the full amount, or some proportion, of benefits paid to an insured individual. Example: if a claimant who received benefits under a state's statutory plan covering disability benefits enter into litigation or make claim against a third party, the insurance carrier has a right to place a lien against any benefit the action may produce.

**Subscriber**: The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health plan.

**Subscriber Contract**: A written agreement describing the individual's healthcare policy. This may also be called a subscriber certificate, or a member certificate or policy.

**Sub-specialist**: A physician who has completed additional training beyond the residency for

general surgery, internal medicine, pediatrics, etc. For example, internal medicine subspecialties include oncology (cancer), nephrology (kidney disease) and cardiology (heart disease).

**T**

**Termination Date**: The date that a contract expires, or the date that a subscriber and/or covered person ceases to be eligible.

**Third Party Recovery**: Payment made by another plan, person or company that is legally liable for a member's injury (e.g., automobile, medical malpractice, slip and fall, product liability insurance).

**Third Party Payer**: A public or private organization that pays for, or underwrites coverage for, healthcare expenses for an individual or group.

**Traditional**: See **Indemnity**.

**Transitional Care Unit**: A transitional care center (TCU) is a Medicare-licensed facility that provides skilled nursing services or rehabilitation services as ordered by a physician. A TCU is typically based within a hospital facility.

**Treatment Facility**: A residential or non-residential facility or program licensed, certified or otherwise authorized to provide treatment of substance abuse or mental illness.

**Triage**: The classification of sick or injured persons according to severity for the purpose of directing care and ensuring efficient use of medical and nursing staff and facilities.

**U**

**UB-04**: See **Uniform Billing**.

**Urgent Care Clinic**: A clinic that provides health services for members with minor emergencies and illnesses.

**Usual, Customary & Reasonable (**UCR):

- **Usual**: The fee charged most of the time for the majority of patients for a specific service.
- **Customary**: The average fee charged by physicians in a specific locality.
- **Reasonable**: The actual charge submitted on a claim for services.

**Utilization Review**: A formal assessment of the medical necessity, efficiency, and/or appropriateness of healthcare services and treatment plans on a prospective, concurrent or retrospective basis.

**V**

**Voucher**: A document that accompanies a check to a participating practitioner showing the amount paid for covered services, as well as indicating denied services.

**W**

**Waiting Period**: A period of time from the date of original enrollment of a member in which no benefits are paid for certain conditions or procedures.

**Workers' Compensation**: A state-governed system designed to address work-related conditions/injuries. Under the system, employers assume the cost of medical treatment and wage losses arising from a worker's job-related injury or disease, regardless of who is at fault. In return, employees give up the right to sue employers, even if injuries stem from employer negligence.

**Important:** This glossary is provided for general information purposes to better assist in the understanding of this manual. It is not intended as policy. If a conflict arises, the actual policy, procedure or contract will prevail.