

Health Care Service Corporation Glossary of Terms

Term	Definition
accreditation	An evaluative process in which a healthcare organization undergoes an examination of its operating procedures to determine whether the procedures meet designated criteria as defined by the accrediting body, and to ensure that the organization meets a specified level of quality.
ambulatory care facility (ACF)	A medical care center that provides a wide range of healthcare services, including preventive care, acute care, surgery, and outpatient care, in a centralized facility. Also known as a medical clinic or medical center.
ambulatory care group (ACG)	ACGs are a method of categorizing outpatient episodes. There are 51 mutually exclusive ACGs which are based on resource use over time and are modified by principal diagnosis, age and sex. See also ADG and APG.
ambulatory diagnostic group (ADG)	ADGs are a method of categorizing outpatient episodes. There are 34 possible ADGs. See ACG and APG.
ambulatory patient group (APG)	A reimbursement methodology developed by 3M Health Information Systems for HCFA. APGs are to outpatient procedures what DRGs are to inpatient days. APGs provide for a fixed reimbursement to an institution for outpatient procedures or visits and incorporate data regarding the reason for the visit and patient data. APGs prevent unbundling of ancillary services. See also ACG and ADG.
ambulatory payment classification (APC)	Medicare payment methodology for outpatient prospective payment system. APCs are categorized as significant procedures, surgical procedures, medical visits, ancillary tests and procedures, partial hospitalization. While APCs incorporate most covered hospital outpatient services (e.g., surgical procedures, radiology, cancer chemotherapy), APCs do not cover those outpatient services already paid under fee schedules or other prospectively determined rates (e.g., screening mammographies, ambulance services, clinical diagnostic lab services).
ancillary services	Auxiliary or supplemental services, such as diagnostic services, home health services, physical therapy, and occupational therapy, used to support diagnosis and treatment of a patient's condition.
appropriate care	A diagnostic or treatment measure whose expected health benefits exceed its expected health risks by a wide enough margin to justify the measure.
appropriateness review	An analysis of healthcare services with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided.
ASO	Administrative services only (sometimes referred to as an administrative services contract [ASC]). A contract between an insurance company and a self-funded plan where the insurance company performs administrative services only and does not assume any risk. Services usually include claims processing but may include other services such as actuarial analysis and utilization review.
balance billing	When a provider bills above the contracted amount for covered services.
behavioral healthcare	The provision of mental health and substance abuse services.
benchmarking	The comparison of a managed care organization's clinical and operational practices or outcomes to those of other organizations with the goal of identifying the practices that lead to the best outcomes and implementing those practices to achieve overall quality improvement.
board certified	A term for a physician who has completed residency training in a medical specialty and has passed a written examination in that specialty.

Health Care Service Corporation Glossary of Terms

Term	Definition
capitation	A method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person served, without regard to the actual number or nature of services provided to each person.
case management	A process of identifying plan members with special healthcare needs, developing a healthcare strategy that meets those needs, and coordinating and monitoring the care, with the ultimate goal of achieving the optimum healthcare outcome in an efficient and cost-effective manner. Also known as large case management (LCM).
case price	A negotiated flat rate for certain categories of procedures and can be referred to as a case rate. The most common of these is obstetrics. It is common to negotiate a flat rate for a normal vaginal delivery and a flat rate for a cesarean section or a blended rate for both. Package pricing or bundled case rate refers to an all-inclusive rate paid for both institutional and professional services. The plan negotiates a flat rate for a procedure (e.g., coronary artery bypass surgery), and that rate is used to pay all parties who provide services connected with that procedure, including preadmission and post discharge care. Bundled case rates are not uncommon in teaching facilities where there is a faculty practice plan that works closely with the hospital.
clinical integration	A type of operational integration that enables patients to receive a variety of health services from the same organization or entity, which streamlines administrative processes and increases the potential for the delivery of high-quality healthcare.
clinical practice guideline	A utilization and quality management mechanism designed to aid providers in making decisions about the most appropriate course of treatment for a specific clinical case.
clinical status	A type of outcome measure that relates to improvement in biological health status.
closed access	A provision which specifies that plan members must obtain medical services only from network providers through a primary care physician to receive in-network level of benefits.
closed formulary	The provision that only those drugs on a preferred list will be covered by a Pharmacy Benefits Management company (PBM) or MCO.
coinsurance	A method of cost sharing in a health insurance policy that requires a group member to pay a stated percentage of all remaining eligible medical expenses after the deductible amount has been paid.
Computer Physician Order Entry (CPOE)	With CPOE systems, physicians enter medication orders via computer linked to prescribing error prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50%.
concurrent authorization	Authorization to deliver healthcare service that is generated at the time the service is rendered.
consolidated medical group	A large single medical practice that operates in one or a few facilities rather than in many independent offices. The single-specialty or multi-specialty practice group may be formed from previously independent practices and is often owned by a parent company or a hospital. Also known as a medical group practice or clinic model.
copayment	A specified dollar amount that a member must pay out-of-pocket for a specified service at the time the service is rendered.
credentialing	Refers to reviewing, and verifying for accuracy, the documentation of professional providers. Such documentation may include, but is not necessarily limited to, licensure, certifications, insurance, and malpractice history.

Health Care Service Corporation Glossary of Terms

Term	Definition
credentialing committee	Committee, which may be a subset of the QM committee, that oversees the credentialing process.
deductible	A flat amount a group member must pay before the insurer will make any benefit payments.
demand management	The use of strategies designed to reduce the overall demand for and use of healthcare services, including any benefit offered by a plan that encourages preventive care, wellness, member self-care, and appropriate utilization of health services.
diagnosis-related groups (DRG)	DRGs are used to determine the amount Medicare reimburses each hospital that provides its insureds with service as part of its prospective payment system. Each DRG corresponds to a patient condition.
diagnostic and treatment codes	Special codes that consist of a brief, specific description of each diagnosis or treatment and a number used to identify each diagnosis and treatment.
disease management (DM)	A coordinated, proactive, disease-specific approach to patient care that seeks to produce the best clinical outcomes in the most cost-effective manner. It is a medical delivery systems approach that spans the entire continuum of care, from prevention and patient education to diagnosis and treatment to follow-up care and ongoing health maintenance. Data analysis, practice guidelines, provider and patient education, specialty networks and services, and outcome assessment are key components to disease management.
disease state management	See disease management.
drug utilization review (DUR)	A review program that evaluates whether drugs are being used safely, effectively, and appropriately.
eligible provider	Is licensed to render the particular service to the member and contracts with the local (Host) Plan under one or more of the products listed under the Product Eligibility Provisions of the BlueCard Program Manual. An eligible provider is, at a minimum, required to file out-of-area subscriber's claims with the local (Host) Plan when the service can be delivered through the BlueCard Program. The local Plan's contractual arrangement with the provider must be formal and binding.
encounter	A healthcare visit of any type by an enrollee to a provider of care or services.
encounter report	A report that supplies management information about services provided each time a patient visits a provider.
Evidence-based Hospital Referral	By referring patients needing certain complex medical procedures to hospitals offering the best survival odds based on scientifically valid criteria-such as the number of times a hospital performs these procedures each year-research indicates that a patient's risk of dying could be reduced by more than 30%
fee for service	A traditional means of billing by healthcare providers for each service performed, referring to payment in specific amounts for specific services provided (as opposed to contracted amounts or salary).
fee maximum	See fee schedule.

Health Care Service Corporation Glossary of Terms

Term	Definition
fee schedule	May also be referred to as fee maximum, fee allowance, or capped fee. A listing of the maximum fee allowances that a health plan will pay for a certain service based on CPT billing codes. The fee determined by an MCO to be acceptable for a procedure or service, which the physician agrees to accept as payment in full.
fee-for-service (FFS) payment system	A system in which the insurer will either reimburse the group member or pay the provider directly for each covered medical expense after the expense has been incurred.
FFS payment system	See fee-for-service payment system.
formulary	A listing of drugs, classified by therapeutic category or disease class, that are considered preferred therapy for a given managed population and that are to be used by an MCO's providers in prescribing medications.
geographic accessibility	Health plan accessibility, generally determined by drive time or number of primary care providers in a service area.
grievance	Formal complaint demanding formal resolution by a managed care plan.
Health Insurance Portability and Accountability Act (HIPAA)	A federal act that protects people who change jobs, are self-employed, or who have pre-existing medical conditions. HIPAA standardizes an approach to the continuation of healthcare benefits for individuals and members of small group health plans and establishes parity between the benefits extended to these individuals and those benefits offered to employees in large group plans. The act also contains provisions designed to ensure that prospective or current enrollees in a group health plan are not discriminated against based on health status.
health maintenance organization (HMO)	A healthcare system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area, usually in return for a fixed, prepaid fee.
Health Plan Employer Data and Information Set (HEDIS®)	A set of standard performance measures that evaluates a health plan's performance.
HEDIS®	See health plan employer data and information set.
hold harmless provision	A provision in the provider contract to not bill members for the difference between billed charges for covered services (excluding coinsurance, deductible, and/or copayment) and the provider's contracted allowance.
ICU Staffing	Staffing ICU's with physicians who have credentials in critical care medicine has been shown to reduce the risk of patients dying in the ICU by more than 10%.
incentive	Incentive payment is a payment above base capitation or fee for service awarded to providers whose performance meets or exceeds established criteria.
independent practice association (IPA)	An organization comprised of individual physicians or physicians in small group practices that contracts with MCOs on behalf of its member physicians to provide healthcare services.

Health Care Service Corporation Glossary of Terms

Term	Definition
integrated delivery system (IDS)	A provider organization that is fully integrated operationally and clinically to provide a full range of healthcare services, including physician services, hospital services, and ancillary services.
IPA	See independent practice association.
large case management (LCM)	See case management.
Leapfrog	The Leapfrog Group is a growing consortium which encourage employers to take safety "leaps" forward with their employees, retirees, and families by helping them make more informed health care choices and by rewarding the hospitals that implement significant safety improvements. Under Leapfrog, employers have agreed to base their purchase of health care principles encouraging more stringent patient safety measures. The Leapfrog Group's initiatives have the potential to save up to 58,300 lives and prevent up to 522,000 medication errors each year (Birkmeyer, 2000).
managed behavioral health organization (MBHO)	An organization that provides behavioral health services using managed care techniques.
managed care	The integration of both the financing and delivery of health care within a system that seeks to manage the accessibility, cost, and quality of that care.
managed care organization (MCO)	Any entity that utilizes certain concepts or techniques to manage the accessibility, cost, and quality of healthcare. Also known as a managed care plan.
managed care plan	See managed care organization (MCO).
MCO	See managed care organization.
medical director	Manager in a healthcare organization responsible for provider relations, provider recruiting, quality and utilization management, and medical policy.
medical necessity review	See prior authorization.
medically necessary	A term used by insurance companies and health plans to describe care that is appropriate and provided according to general standards of medical practice. Care provided or referred by your PCP is always considered medically necessary. Self referred or out-of-network care is covered only if it is medically necessary and appropriate.
member services	The department responsible for helping members with any problems, handling member grievances and complaints, tracking and reporting patterns of problems encountered, and enhancing the relationship between members of the plan and the plan itself.
Mental Health Parity Act (MHPA)	A federal act which prohibits group health plans that offer mental health benefits from applying more restrictive limits on coverage for mental illness than for physical illness.

Health Care Service Corporation Glossary of Terms

Term	Definition
MHPA	See Mental Health Parity Act.
Milliman and Robertson	The Milliman and Robertson Care Guidelines is a nine volume series that spans the continuum of patient care-the Guidelines describe the best practices for treating common conditions in a variety of care settings.
national accounts	Large group accounts that have employees in more than one geographic area that are covered through a single national contract for health coverage. Contrast with large local groups.
National Committee on Quality Assurance (NCQA)	A voluntary accreditation organization for HMO and POS products.
NCQA accreditation	The National Committee for Quality Assurance (NCQA) is a voluntary, nonprofit agency which evaluates and then accredits managed care plans based on their compliance with stringent quality criteria. There are currently over 275 plans accredited by NCQA across the country.
NCQA Accreditation Levels	<p>Excellent (not previously used) - NCQA's highest accreditation status is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS results that are in the highest range of national or regional performance.</p> <p>Commendable (was Full Accreditation) - This accreditation level is awarded to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.</p> <p>Accredited (was One-Year Accreditation) - Health plans that earn the 'Accredited' designation must meet most of NCQA's requirements for consumer protection and quality improvement.</p> <p>Provisional (No change) - Provisional accreditation indicates that a health plan's service and clinical quality meet some, but not all of NCQA's requirements for consumer protection and quality improvement.</p> <p>Denied (No change) - Denied is an indication that a health plan did not meet NCQA's requirements during its review.</p>
network	The group of physicians, hospitals, and other medical care providers that a specific managed care plan has contracted with to deliver medical services to its members.
no balance billing provision	A provider contract clause which states that the provider agrees to accept the amount the plan pays for medical services as payment in full and not to bill plan members for additional amounts (except for copayments, coinsurance, and deductibles).
open access	A provision that specifies that plan members may self-refer to a specialist, either in-network or out-of-network, at full benefit or at a reduced benefit, without first obtaining a referral from a primary care provider.

Health Care Service Corporation Glossary of Terms

Term	Definition
Optimed	<p>Optimed is an evidence-based, automated utilization management system developed by Optimed Medical Systems. It has been used for over 10 years and is used nationally to perform utilization management for than 22 million health plan members. The Portable Optimed Protocols have been interfaced with the BCC Utilization Management System (GNQ) to create an integrated application for utilization management.</p> <p>Key characteristics of Optimed include: objective criteria based on medical literature review, best current practices, and national panel review; required specific measurable information; defined terminology; consistent review process with specific objective PA referral criteria; updates at least annually.</p>
outcomes measures	Healthcare quality indicators that gauge the extent to which healthcare services succeed in improving patient health.
outpatient care	Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.
Patient Bill of Rights	Refers to the Consumer Bill of Rights and Responsibilities, a report prepared by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in an effort to ensure the security of patient information, promote healthcare quality, and improve the availability of healthcare treatment and services. The report lists a number of "rights," subdivided into eight general areas, that all healthcare consumers should be guaranteed and describes responsibilities that consumers need to accept for the sake of their own health.
PCP	See primary care physician.
personal care physician	See primary care physician.
PMG	Primary Medical Group
point of service (POS)	Health benefit program in which the highest level of benefits is received when the enrollee obtains services from or at the direction of his or her designated primary care physician gatekeeper. Substantial benefits are still provided when the enrollee obtains care from a provider of choice, without gatekeeper approval.
POS product	See point-of-service product.
PPO	See preferred provider organization.
preauthorization	The process whereby the primary care physician, or other designated selected specialist physician, must contact the BCBS Plan's designated agent to determine the eligibility of coverage for and/or the medical necessity or appropriateness of certain covered services. Such authorization must be obtained prior to providing or authorizing covered services for members. If the primary care physician or other designated selected specialist physician is required to obtain authorization and provides or authorizes covered services without obtaining an authorization, the member will not be responsible for payment.
precertification	Also known as preadmission certification, preadmission review and precert. The process of obtaining certification or authorization from the health plan for routine hospital admissions (inpatient or outpatient). Often involves appropriateness review against criteria and assignment of length of stay. Failure to obtain precertification often results in financial penalty to either the provider or the subscriber.

Health Care Service Corporation Glossary of Terms

Term	Definition
preferred provider organization (PPO)	A health benefit program that offers the highest level of benefits to members when they obtain services from any physician or hospital designated as a PPO provider. Substantial benefits are still provided when the member obtains care from another provider of choice. No primary care physician gatekeeper/referral is required for access to PPO providers. The PPO provider network includes, at a minimum, hospitals and physicians and may include other health care providers.
preventive care	Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination, immunization, and well-person care.
primary care	General medical care that is provided directly to a patient without referral from another physician. It is focused on preventive care and the treatment of routine injuries and illnesses.
primary care physician (PCP)	A doctor chosen by members and their covered family members to coordinate all medical services and treatment to ensure appropriate and cost-effective care. PCPs include family practitioners, general practitioners, internists and pediatricians. Through the PCP, members are referred to specialists or health care centers as needed. (Also called doctor of choice (DOC) or preferred doctor.) Each family member may have a different doctor serve as the PCP; the only restriction is that all PCPs for one family must come from the same network.
prior authorization	In the context of a pharmacy benefit management (PBM) plan, a program that requires physicians to obtain certification of medical necessity prior to drug dispensing. Also known as a medical-necessity review.
profiling	Profiling is an analytical tool that uses epidemiologic methods to compare practice patterns of providers on the dimensions of cost, service use, or quality of care. The provider's pattern of practice is expressed as a rate, aggregated over time, for a defined population of patients.
prospective authorization	Authorization to deliver healthcare service that is issued before any service is rendered. Also known as a precertification.
provider profiling	Profiling focuses on the patterns of a provider's care rather than that provider's specific clinical decisions. The practice pattern of an individual provider is expressed as a rate or measure of resource use during a defined period and for a defined population. The resulting profile can then be compared against a peer group or standard. Examples of measures used in profiling include average wait time to schedule a routine physical, number of hospital admissions, number of referrals out of network, percentage of children receiving immunizations, etc.
QM	See quality management.
QM committee	MCO committee responsible for oversight of the quality management program - including the setting of standards, review of data, feedback to providers, follow-up, and approval of sanctions - and for the quality of care delivered to members.
quality management (QM)	An organization-wide process of measuring and improving the quality of the healthcare provided by an MCO.
quality program	An organization-wide initiative to measure and improve the service and care provided by an MCO.
RBRVS	See Resource-Based Relative Value Scale.
recredentialing	Reexamination by an MCO of the qualifications of a provider and verification that the provider still meets the standards for participation in the network.

Health Care Service Corporation Glossary of Terms

Term	Definition
referral/authorization	In managed care benefit programs, a "referral" can be a documented approval from a primary care physician for a subscriber to visit another provider. The referral allows the provider to render services specified on the referral without penalty. The requirement for a referral varies from Plan to Plan. An "authorization" can be the review and assessment by a Plan concerning the medical necessity and appropriateness of a hospitalization or patient care.
resource-based relative value scale (RBRVS)	A method used by MCOs of determining provider reimbursement that attempts to take into account, when assigning a weighted value to medical procedures or services, all resources that physicians use in providing care to patients, including physical or procedural, educational, mental (cognitive), and financial resources.
retrospective authorization	Authorization to deliver healthcare service that is granted after service has been rendered.
standard of care	A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance.
transition/continuity of care	The continuous coverage of a member that transfers from one Plan or line of business to another. Maintenance of continuity of care ensures there are no gaps in coverage of a condition that requires a continuing pan of care, and that all claims are processed with the appropriate Plan. Transition/continuity of care is subject to Plan Medical Director approval prior to the effective date of new coverage. Examples of conditions that may require transition/continuity of care include, but are not limited to, maternity care, dialysis, chemotherapy, and radiation therapy. A member utilizing transition/continuity of care is not guaranteed identical coverage.
UCR fee	See usual, customary, and reasonable fee.
UM	See utilization management.
UR	See utilization review.
URO	Utilization review organization. See utilization review committee.
usual, customary, and reasonable (UCR) fee	The amount commonly charged for a particular medical service by physicians within a particular geographic region. UCR fees are used by traditional health insurance companies as the basis for physician reimbursement.
utilization management (UM)	Managing the use of medical services to ensure that a patient receives necessary, appropriate, high-quality care in a cost-effective manner.
utilization review (UR)	The evaluation of the medical necessity, efficiency, and/or appropriateness of healthcare services and treatment plans.
utilization review committee	Committee that reviews utilization issues brought to it by the medical director, often approving or reviewing policy regarding coverage, reviewing utilization patterns of providers, and approving or reviewing the sanctioning process against providers.
wellness programs	Are designed to keep the member free of disease. Examples of wellness programs include, but are not limited to, smoking cessation, nutritional counseling, and stress reduction.

Health Care Service Corporation Glossary of Terms

Term	Definition
withhold	A percentage of a provider's payment that is "held back" during the plan year to offset or pay for any cost overruns for referral or hospital services. Any part of the withhold not used for these purposes is distributed to providers.