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# Glossary and Abbreviations



**K.2** Glossary of Health Care Terms


**K.11** Abbreviations

# *Glossary of Health Care Terms*




Several health care terms in this glossary have two types of definitions:

Health care industry definitions—identified in the glossary with the symbol HCID

(  )—explain these terms in language commonly used and generally accepted by the health care industry, including UPMC Health Plan.

Statutory/regulatory definitions—identified in the glossary with the symbol SRD

(  )—explain these terms in language that is mandated by law or regulatory agencies.

The glossary is not intended to be all-inclusive, but it does cover most of the key terms encountered in this manual.



Alert

If a term has a “statutory/regulatory” definition, that definition takes precedence over any “health care industry” definition.

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### Complaint

**SRD** A dispute or objection regarding a network provider or the coverage, operations, or management policies of a managed care plan that has not been resolved by the managed care plan and has been filed with the plan or with the Pennsylvania Department of Health or the Pennsylvania Insurance Department. A complaint is not the same as a grievance.

### Coordinated Care

**HCID** Describes the linking of treatments or services necessary to obtain an optimum level of health care required by the member and provided by appropriate providers.

### Coordination of Benefits (COB)

**HCID** The process to prevent duplicate payment of medical expenses when two or more insurance plans or government benefits plans provide coverage to the same person. The rules that determine which insurer provides primary or secondary insurance are governed by health care industry standards and, in some instances, by applicable regulatory agencies.

### Copayment

**HCID** Cost-sharing arrangement in which the member pays a specified flat amount for a specific service (such as an office visit or prescription drugs).

### Covered Services

**HCID** Health care services for which a health plan is responsible for payment according to the benefit package purchased by the member.

### Credentialing

**HCID** The Health Plan's review procedure that requires that potential or existing network providers meet certain standards in order to begin or continue participation in the network of the Health Plan. The credentialing process may include examination of a provider's certifications, licensures, training, privileges,

and professional competence.

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## D

### Deductible

**HCID** Amount member must pay for covered services before the health plan begins to pay for such services.

### Disenrollment

**HCID** Process of termination of a member's coverage.

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## E

### Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

**SRD** Items and services which must be made available to Medical Assistance beneficiaries who are under the age of 21, including UPMC *for You* members, upon a determination of medical necessity and required by federal law at 42 U.S.C. §1396d(r). Emergency Service

**SRD** Any health care service provided to a member after sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the member (or for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an

emergency service, if the condition of the member is as described above.

### Enrollment

**HCID** Process by which a health plan signs up groups and individuals for membership.

### Exclusive Provider Organization (EPO)

**HCID** Plan that blends elements of a traditional HMO with the elements of a PPO. Members are not required to select a PCP. Members receive care at any network provider or facility to ensure coverage.

### Explanation of Benefits (EOB)

**HCID** Statement sent to a member by the Health Plan that explains the benefits provided; the allowable reimbursement amounts; any deductibles, coinsurance, or other adjustments taken; and the net amount paid.

### Explanation of Payment (EOP)

**HCID** A summary of covered services for which the Health Plan paid a provider. Also known as a remittance advice, the EOP shows the date of service, diagnosis, and procedure performed as well as all payment information, including explanation codes for those claims denied or returned for correction.

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## G

### Grievance

**SRD** Request by a member, or by a health care provider with written consent of a member, to have a managed care plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding a decision that:

- disapproves full or partial payment for a requested health care service,
- approves provision of a requested health care service for lesser scope or duration than requested, or

- disapproves payment for the provision of a requested health care service but approves payment for provision of an alternative health care service.

A grievance is not the same as a complaint.

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## H

### Health Maintenance Organization (HMO)

**SRD** An organized system that combines the delivery and financing of health care and that provides basic health services to voluntarily enrolled members for a fixed prepaid price.

### Health Plan Employer Data Information Set (HEDIS)

**HCID** A core set of performance measures developed and managed by the National Committee for Quality Assurance (NCQA) to assist employers and other purchasers in evaluating health plan performance. Also used by government agencies to monitor quality of care provided or arranged by health plans.

### Home Medical Equipment (HME)

**HCID** Medical equipment owned or rented by a member and placed in the home of that member to facilitate treatment and/or rehabilitation. HME was formerly known as durable medical equipment.

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### Indemnity Plan (also known as fee-for-service)

**HCID** A health plan that reimburses a member of the plan for medical services based on bills submitted after services are rendered. It does not typically cover all outpatient services or preventive care programs. Usually no restrictions are placed on selecting providers or facilities, and



reasonably expected to, prevent the onset of an illness, condition, or disability;

- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

### Medically Necessary, continued

#### *For Medicare*

Medical or hospital services that are determined by the Medicare Advantage organization to be:

- Rendered for the treatment or diagnosis of an injury or illness; and
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the member, the attending physician, or other provider of service.

Whether there is “sufficient scientific evidence” shall be determined by the Medicare Advantage organization based on the following: peer-reviewed medical literature; publications, reports, evaluations, and regulations issued by state and federal government agencies, Medicare local carriers, and intermediaries; and such other authoritative medical sources as deemed necessary by the Medicare Advantage organization.

### Medicare Advantage Plan

**SRD** Plan of coverage for health benefits under Medicare Part C as defined in Section

1859 of the Social Security Act (42 U.S.C. § 1395 at W-28).

- Coordinated care plans that provide health care services, including health maintenance organization (HMO) plans (with or without point-of-service [POS] option), plans offered by provider-sponsored organizations and preferred provider organization (PPO) plans.
- Medicare medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account.
- Medicare Advantage private fee-for-service plans.

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## N

### NCQA Accreditation

**HCID** National Committee for Quality Assurance (NCQA) is a voluntary, nonprofit agency that evaluates and then accredits managed care plans based on their compliance with stringent quality criteria developed by NCQA. Across the country, some 300 health plans are accredited by NCQA.

### Network

**HCID** Group of physicians, hospitals, laboratories, and other health care providers who participate in a health plan’s health care delivery system. The providers agree to undergo the health plan’s credentialing process, follow the health plan’s policies and procedures, submit to monitoring of their practices, and provide services to members at contracted rates.

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## O

### Out-of-Area

**HCID** Care for illness or injury that is delivered to members traveling outside UPMC Health Plan’s service area.

### Out-of-Network

**HCID** Care performed by providers who do not participate in the UPMC Health Plan network.

### Out-of-Pocket

**HCID** Total payments toward eligible expenses that a member funds for himself/herself and/or dependents, including copayments, coinsurance, and deductibles.



## P

### Participating or Network Provider

**HCID** Facility, hospital, doctor, or other health care provider that has been credentialed by and has a contract with a health plan to provide services.

### Point of Service (POS)

**HCID** Health plan that specifies that those members who receive health care services outside of the health plan network may pay greater out-of-pocket expenses.

### Preferred Provider Organization (PPO)

**HCID** Type of managed care in which providers and hospitals agree to provide services at contracted rates. The plan pays the network rates as long as the member sees a network provider. Typically, members need not file claims or coordinate their care through a PCP. When out-of-network providers are used, members pay more of their expenses and usually must file claims.

### Primary Care Provider (PCP)

**SRD** A health care provider who, within the scope of the provider's practice, supervises, coordinates, prescribes, or otherwise provides or proposes to provide health care services to a member; initiates member referral for specialist care; and maintains continuity of member care.



## R

### Reasonable and Customary Charges

**HCID** The average fee charged by a particular type of health care provider within a geographic area. A network provider agrees to accept the plan's payment as payment in full, even though the reasonable and customary charges may be greater than the amount paid by the health plan.

### Rider

**HCID** An additional benefit package beyond the basic coverage package that members may select. Examples of riders include pharmacy benefits, infertility treatment, and vision services.

### Remittance Advice

**HCID** A summary of covered services for which the Health Plan paid a provider. Also known as an Explanation of Payment (EOP), the remittance advice shows the date of service, diagnosis, and procedure performed as well as all payment information, including explanation codes for those claims denied or returned for correction.



## S

### Self-Directed or Self-Referred Care

**HCID** Care that members seek directly from network or out-of-network providers as opposed to care coordinated by their PCP or ob-gyn. Self-directed care may require a higher copayment than care coordinated through a member's PCP.

### Specialist

**HCID** Doctor who specializes in a particular branch of medicine, such as cardiology, dermatology, orthopedics, or surgery.





FDA—Food and Drug Administration



H

HCFA—Health Care Financing Administration

HEDIS—Health Plan Employer Data and Information Set

Hib—Haemophilus Influenzae Type B vaccine

HME—Home Medical Equipment

HMO—Health Maintenance Organization



I

ID—Identification

IPV—Inactivated Polio Vaccine



M

MATP—Medical Assistance Transportation Program

MD—Medical Doctor

MH/MR—Mental Health/ Mental Retardation

MMR—Measles, Mumps, and Rubella vaccine



N

NCQA—National Committee for Quality Assurance

NDC#—National Drug Code number

NSAIDs—Non Steroidal Anti-Inflammatory Drugs



O

OB-GYN—Obstetrician-Gynecologist

OBRA 90—Omnibus Budget Reconciliation Act of

OTC—Over-the-Counter



P

PA—Certified Physician Assistant

PCP—Primary Care Provider

PCV—Pneumococcal Conjugate vaccine -Pevnar®

PH-MCO—Physical Health Managed Care Organization

PHO—Physician Hospital Organization

POS—Point-of-Service

PPO—Preferred Provider Organization



Q

QIC—Quality Improvement Committee



T

Td—Tetanus and Diphtheria vaccine

TEE—Transesophageal Echocardiography

TENS—Transcutaneous Electrical Nerve Stimulation

TMJ—Temporomandibular Joint Dysfunction



U

UB—Uniform Billing code

UPIN—Universal Provider Identification Number



V

VBA—Vision Benefits of America

VFC—Vaccines For Children

VZV—Varicella (chicken pox) vaccine