Glossary and Abbreviations

K.2  Glossary of Health Care Terms
K.11  Abbreviations
Several health care terms in this glossary have two types of definitions:

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

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

Statutory/Regulatory Definition

A

Advance Directive
A written document that states how and by whom a member wants medical decisions to be made if that member loses the ability to make such decisions for himself or herself. The two most common forms of advance directives are living wills and durable powers of attorney.

Ancillary Services
A health care service that is not directly available to members but is provided as a consequence of another covered health care service. Radiology, pathology, laboratory, and anesthesiology are examples of ancillary services.

B

Benefit Plan
The schedule of benefits establishing the terms and conditions pursuant to which members enrolled in UPMC Health Plan products receive covered services. A benefit plan includes, but is not limited to, the following information: a schedule of covered services; if applicable, copayment, coinsurance, deductible, and/or out-of-pocket maximum amounts; excluded services; and limitations on covered services (e.g., limits on amount, duration, or scope of services).

Board-Certified
Term describing a physician who has completed residency training in a medical specialty and has passed a written and oral examination established in that specialty by a national board of review.

C

Certificate of Coverage
Legal document that sets forth all of the terms and conditions of a member’s eligibility and coverage in a benefit plan. It includes the schedule of benefits that outlines covered services and provides information on such topics as the member’s right to file a complaint or grievance and continuity of care.

Claim
A request by a health care provider for payment for services rendered to a member.

Clean Claim
A claim for payment for a health care service that has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud and abuse regarding that claim.

Coinsurance
A cost-sharing requirement under a health insurance plan that provides that a member will assume responsibility for payment of a fixed amount or percentage of the cost of a covered service.

Commercial Plan
A UPMC Health Plan product that provides health benefit coverage to employer groups and individuals. Commercial products include an Enhanced Access Health Maintenance Organization (EAHMO), an Enhanced Access Point of Service (EAPOS), an Exclusive Provider Organization (EPO), a Preferred Provider Organization (PPO), and a Consumer Directed Health Plan (CDHP).
Complaint
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
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)
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
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
Health care services for which a health plan is responsible for payment according to the benefit package purchased by the member.

Credentialing
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.

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

Disenrollment
Process of termination of a member’s coverage.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
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
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**
- Process by which a health plan signs up groups and individuals for membership.

**Exclusive Provider Organization (EPO)**
- 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)**
- 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)**
- 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.

**Grievance**
- 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.

**Health Maintenance Organization (HMO)**
- 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)**
- 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)**
- 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.

**Indemnity Plan (also known as fee-for-service)**
- 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
members pay a percentage of the charge for services.

**Integrated Delivery System**

A partnership, association, corporation, or other legal entity that does the following:

- Enters into a contractual agreement with a health plan.
- Employs or contracts with health care providers.
- Agrees under its arrangement with the health plan to do the following:
  1. Provide or arrange for the provision of a defined set of health care services to members covered under a plan contract principally through its participating providers.
  2. Assume under the arrangement with the plan some responsibility for conducting, in conjunction with the plan and under compliance monitoring of the plan, quality assurance, utilization review, credentialing, provider relations, or related functions.

The IDS also may perform claims processing and other functions.

**Medically Necessary**

*For Commercial Products*

Services or supplies are determined to be medically necessary if they are:

- Commonly recognized throughout the provider’s specialty as appropriate for the diagnosis and/or treatment of the member’s condition, illness, disease, or injury; and
- Provided in accordance with standards of good medical practice and consistent with scientifically based guidelines of medical, research, or health care coverage organizations or governmental agencies that are accepted by UPMC Health Plan; and
- Can reasonably be expected to improve an individual’s condition or level of functioning; and
- In conformity, at the time of treatment, with medical management criteria adopted by UPMC Health Plan or its designee; and
- Not provided only as a convenience or comfort measure or to improve physical appearance; and
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

UPMC Health Plan reserves the right to determine in its sole judgment whether a service meets these criteria and will be authorized for payment. Authorization for payment decisions shall be made by UPMC Health Plan with input from the member’s PCP or other provider performing the service. Independent consultation with a provider other than the PCP or attending physician may be obtained at the discretion of UPMC Health Plan.

The fact that a physician or other health care provider may order, prescribe, recommend, or approve a service, supply, or therapeutic regimen does not, of itself, determine medical necessity and appropriateness or make such a service, supply, or treatment a covered service.

*For Medical Assistance*

Determinations of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, or postutilization basis, shall be in writing and be compensable under Medical Assistance. The Physical Health-Managed Care Organization (PH-MCO) shall base its determination on medical information provided by the member, the member’s family or caretaker, and the PCP, as well as any other providers, programs, and agencies that have evaluated the member.

- Medical necessity determinations must be made by qualified and trained providers. Satisfaction of any one of the following standards will result in authorization of the service:
- The service or benefit will, or is
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
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.

NCQA Accreditation
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
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.

Out-of-Network
Care for illness or injury that is delivered to members traveling outside UPMC Health Plan’s service area.
Glossary and Abbreviations

**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.
UPMC for Life

A UPMC Medicare Advantage product providing coverage for health benefits to individuals eligible to participate in the federal Medicare program. UPMC Health Plan offers both an HMO and a PPO option for those individuals.

UPMC for You

A UPMC Health Plan HMO product providing coverage for health benefits to individuals eligible to participate in the Medical Assistance program of the Commonwealth of Pennsylvania.

UPMC for Kids

The UPMC for Kids program is UPMC Health Plan’s, Children’s Health Insurance program (CHIP), a state and federally funded program that provides health insurance for eligible uninsured children and teens.

UPMC for Life Specialty Plan (SNP)

UPMC for Life Specialty Plan is a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan that serves dual eligible Medicare beneficiaries. That is, beneficiaries who meet the following criteria:

- Entitled to Medicare Part A
- Enrolled in Medicare Part B
- Have full Medical Assistance coverage
- Have not been confined to an institution for more than 90 days
- Do not have End Stage Renal Disease (ESRD), unless currently enrolled in another UPMC product
Abbreviations

A
ADA—Americans with Disabilities Act

B
ASA—American Society of Anesthesiologists
BHS—UPMC Health Plan Behavioral Health Services
DPM—Doctor of Podiatric Medicine
DTaP—Diphtheria, Tetanus and Acellular Pertussis vaccine
DPW—Department of Public Welfare

C
CAT—(Pennsylvania) Medical Professional Liability Catastrophic Loss Fund
CCBH—Community Care Behavioral Health
CCI—Correct Coding Initiative (CMS)
CDC—Centers for Disease Control
CLIA—Clinical Laboratory Improvement Amendments
CME—Continuing Medical Education (credits)
CMS—Centers for Medicare and Medicaid Services
CNM—Certified Nurse Midwife
COB—Coordination of Benefits
CRE—Certified Review Entity
CRNA—Certified Registered Nurse Anesthetist
CRNP—Certified Registered Nurse Practitioner

D
DO—Doctor of Osteopathy

E
EAP—Employee Assistance Program
EAHMO—Enhanced Access Health Maintenance Organization
EAPOS—Enhanced Access Point-of-Service
EPO—Exclusive Provider Organization
EM—Enhanced Management or Evaluation and Management code
EOB—Explanation of Benefits
EOP—Explanation of Payment
EPSDT—Early and Periodic Screening, Diagnosis, and Treatment
ESRD—End-Stage Renal Disease
EVS—Electronic Verification System

F
## Glossary and Abbreviations

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<tr>
<th><strong>Abbreviation</strong></th>
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<tbody>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
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<tr>
<td>NDC#</td>
<td>National Drug Code number</td>
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<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
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<tr>
<td>O</td>
<td>Obstetrician-Gynecologist</td>
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<tr>
<td>NHCA</td>
<td>National Committee for Quality Assurance</td>
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<tr>
<td>Hiib</td>
<td>Haemophilus Influenzae Type B vaccine</td>
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<tr>
<td>OTC</td>
<td>Over-the-Counter</td>
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<tr>
<td>HME</td>
<td>Home Medical Equipment</td>
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<td>P</td>
<td>Certified Physician Assistant</td>
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<tr>
<td>MME</td>
<td>Measles, Mumps, and Rubella vaccine</td>
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<tr>
<td>PA</td>
<td>Primary Care Provider</td>
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<tr>
<td>MATP</td>
<td>Medical Assistance Transportation Program</td>
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<tr>
<td>MD</td>
<td>Medical Doctor</td>
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<tr>
<td>MH/MR</td>
<td>Mental Health/ Mental Retardation</td>
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<tr>
<td>MCV</td>
<td>Pneumococcal Conjugate vaccine -Prevnar®</td>
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<tr>
<td>PH-MCO</td>
<td>Physical Health Managed Care Organization</td>
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<td>OBRA 90</td>
<td>Omnibus Budget Reconciliation Act of</td>
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<tr>
<td>OTC</td>
<td>Over-the-Counter</td>
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<td>QIC</td>
<td>Quality Improvement Committee</td>
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<tr>
<td><strong>Td</strong></td>
<td>Tetanus and Diphtheria vaccine</td>
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<td><strong>TEE</strong></td>
<td>Transesophageal Echocardiography</td>
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<td><strong>TENS</strong></td>
<td>Transcutaneous Electrical Nerve Stimulation</td>
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<td><strong>TMJ</strong></td>
<td>Temporomandibular Joint Dysfunction</td>
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<td><strong>V</strong></td>
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<tr>
<td><strong>VBA</strong></td>
<td>Vision Benefits of America</td>
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<td><strong>VFC</strong></td>
<td>Vaccines For Children</td>
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<tr>
<td><strong>VZV</strong></td>
<td>Varicella (chicken pox) vaccine</td>
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<tr>
<td><strong>UB</strong></td>
<td>Uniform Billing code</td>
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<tr>
<td><strong>UPIN</strong></td>
<td>Universal Provider Identification Number</td>
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