



Glossary

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These definitions are for general reference and convenience only and are subject to modification by the terms of your provider contract or member health plan or policy which shall be the control in the event of any conflict.

A

Accidental Injury

An injury to the body caused solely through external, violent and accidental means. "Accidental Injury" does **not** include disease or infection (unless it's pus-producing infection that occurred from an accidental cut or wound); hernia; injuries caused by biting or chewing.

Actual Charge

Administrative Services Only Group (ASO)

Agreement

Refers to the legal Agreement(s) between Blue Cross and Blue Shield of Kansas and the facility or other providers that are included in the policies and procedures manual.

Allowable Charge

Alpha Prefix

The 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 Surgical Center (ASC)

ASC are facilities that meet all the following criteria: (1) is licensed by the proper licensing agency as an ambulatory surgical center; (2) is not a part of the hospital; (3) provides hospital-type services for outpatient surgery; (4) shall not include the offices of private physicians or dentists, whether for individual or group practice.

Anniversary Date

Anniversary Year

Appeal

This is a written request, except in cases of urgent care in which the request may be submitted orally or in writing, for review of denied claims.

Assignment of Benefits

B

Benefit Period

Biologically Based Nervous or Mental Condition

Includes the following as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association:

1. Schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis;
2. major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders;
3. obsessive compulsive disorders;
4. panic disorders;
5. pervasive developmental disorders, including autism;
6. attention deficit disorders and attention deficit hyperactive disorders

Blue Cross and Blue Shield Association

National Association of Independent Blue Cross and Blue Shield Plans; the organization which works to coordinate the efforts of on-site Blue Cross and Blue Shield Plans at the national level.

Blue Cross and Blue Shield of Kansas Plan Area

Includes all counties in the State of Kansas except Johnson and Wyandotte counties.

BlueCard®

BlueCard Access®

A toll-free number (1-800-810-BLUE) for you and members to use to locate current participating healthcare providers in another Blue Plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

BlueCard Doctor & Hospital Finder Web Site

A Web site (<http://www.bcbs.com/healthtravel/finder.html>) you can use to locate current participating providers in other Blue Plan areas.

BlueCard Eligibility®

A toll-free number (1-800-676-BLUE) for you to use to verify membership and coverage, as well as obtain pre-certification on patients from other Blue Plans.

BlueCares.com

Blue Cross and Blue Shield Association Web site, which contains useful information for providers.

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

Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.

**BlueCard Worldwide®**

A program that allows Blue 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 Blue Cross and/or Blue Plans to access domestic (U.S.) Blue provider networks.

C

Calendar Year

Cardiac Rehabilitation

Use of various modalities of treatment to improve cardiac function as well as tissue perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-illness level of activity or a new and appropriate level of adjustment.

Case Management

Centers for Medicare and Medicaid services (CMS)

A branch of the Department of Health and Human Services (DHHS) that oversees the financing of health care through programs such as Medicare and Medicaid.

Claim

A billing record generated and submitted by a provider or member using either paper or electronic media.

Coinsurance

Company Service Area

Competitive Allowance Program (CAP)

Comprehensive Major Medical (CMM)

A traditional health benefit design characterized by cost sharing features, such as a deductible amount, a coinsurance feature and maximum benefits. It is designed to give the protection offered by both a basic hospital, basic medical/surgical and supplemental major medical health benefit design. A CMM benefit does not distinguish between basic and major medical benefits.

Concurrent Review

The review of an ongoing inpatient hospitalization to assure that it remains the most appropriate setting for the care being rendered. Participating hospitals are encouraged to obtain extensions in benefits beyond precertification through the Concurrent Review program.

Contract Year

Contracting Provider

Coordination of Benefits

Provisions and procedures used by members to avoid duplicate payment of benefits by more than one insurance policy.

Copayment or Copay

Credible Evidence

Means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating eligible provider(s) or the protocol(s) of other eligible provider(s) providing or studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating eligible provider(s) or by another eligible provider (s) providing or studying substantially the same drug, device, medical treatment or procedure.

Critical Access Hospital (CAH)

A Critical Access Hospital (CAH) is a hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures. Each hospital must review its own situation to determine if CAH status would be advantageous. CAHs are certified under a different set of Medicare Conditions of Participation (CoP) that are more flexible than the acute care hospital CoPs.

Current Procedural Terminology (CPT)

Current Procedural Terminology (CPT) is a book published and updated by the American Medical Association. This book lists descriptive terms and identifying codes for reporting medical services. The procedure code that best describes the services provided is required on claims.

D

[Deductible](#)

[Dependent](#)

[Disease Management](#)

Diagnostic Related Group (DRGs)

A patient classification system, developed for the Centers for Medicare and Medicaid Services (CMS), for classifying hospital or other inpatient facility patients into groups based on criteria of diagnoses, procedures, age, sex and discharge status.

E

Electronic Fund Transfer (EFT)

An electronic commerce that reduces payment cost by replacing paper currency and the check system. Funds are transferred directly into back account.

[Exclusion](#)

Experimental or Investigational

Refers to the status of a drug, device, medical treatment or procedure:

1. if the drug or device cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not Research-Urgent as defined in these definitions;
or

2. if credible evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these definitions; or
 3. if credible evidence shows that the consensus among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these definitions; or
 4. if there is no credible evidence available that would support the use of the drug, device, medical treatment, or procedure compared to the standard means of treatment or diagnosis.
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F

Federal Employee Program (FEP)

The largest nationally underwritten group covering employees of the federal government and their dependents. FEP members have an identification number that starts with the single alpha prefix “R”.

Formulary

This is a list of both Brand and Generic prescription drugs reviewed and updated by the Prescription Benefit Management Company's Pharmacy and Therapeutics Committee. The committee is comprised of physicians and pharmacists. This list is subject to periodic review and modification.

Fraud

Free-standing Birthing Center

This is a facility, operated by a licensed physician, that performs uncomplicated normal/routine (i.e., non-cesarean) deliveries of newborns.

Free-Standing Dialysis Center

This is a facility approved by Medicare to perform dialysis and related services.

Free-Standing Sleep Center/Laboratory

This is a facility that only performs sleep studies.

H

Healthcare Common Procedure Coding System (HCPCS)

Medicare's National Level II codes – HCPCS is a 5-digit alpha-numeric code. This system of coding is an expansion of the CPT coding structure and includes coding for ambulance, home medical equipment, injectibles, etc., which are not available with CPT coding.

Healthcare Financial Management Association (HFMA)

HFMA is the nation's leading membership organization for healthcare financial management executives and leaders. HFMA is a respected leader on top trends and issues facing the healthcare industry.

Health Insurance Portability and Accountability Act (HIPPA)

Legislation with several national, administrative, and financial provisions. Enacted in 1996, it addresses subjects including health care reform, medical savings accounts, COBRA revisions, fraud and abuse. HIPPA Administrative Simplification section mandates specific electronic formats for claims and other transactions. It includes mandates for national identifier, security, and privacy.

Hold Harmless

Provider agreement to not bill the member for the differences between the billed charges for covered services (excluding deductible, coinsurance, and copayment) and the amount the provider contractually agreed with as full payment for those services.

Homebound

A member will be considered homebound if they have a condition due to illness or injury for which leaving the home is medically contraindicated. The Plan has the right to determine whether the patient is home bound.

Home Health Agency

This is a public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the patients' place of residence; has policies established by a group of professional personnel which governs the skilled nursing and therapeutic services which it provides; maintains clinical records on all patients; is licensed according to the State and local laws; and is certified by Medicare.

Hospice

Hospice means a legally constituted organization or agency, centrally administered, medically directed, nurse coordinated program providing comprehensive, continuous outpatient and home-like inpatient care for terminally ill patients and their families. It systematically joins together employed professionals and trained volunteers to form an interdisciplinary group, to assist in providing palliative care and supportive care to meet the special needs arising out of the physical, emotional spiritual, social and economic stresses which are experienced during the final stages of illness and during the dying and bereavement process.

Hospice Team or Interdisciplinary Group

This means the attending physician, and the following hospice personnel: physician, licensed professional or licensed practical nurse, licensed social worker, pastoral or other counselor. Providers of special services, such as mental health, pharmacy, home health aides, trained volunteers and any other appropriate allied health services shall also be included in the interdisciplinary group as the needs of the patient dictate.

Hospital

This is any of the following types of institutions:

- the acute care, psychiatric, rehabilitation and long-term acute care sections of a licensed general hospital;
- other facilities licensed by their state of operation as a hospital that provide acute care services;
- licensed privately operated psychiatric hospitals; and

- health care institutions operated by the State of Kansas or the United States government.

Hospital does **not** include any of the following, even if licensed as a hospital:

- rest homes,
- places that are primarily for the care of convalescents,
- nursing homes,
- skilled nursing facilities,
- health resorts,
- clinics,
- doctors offices,
- private homes,
- ambulatory surgical centers,
- residential or transitional living centers,
- residential treatment centers or similar facilities



Identification Card

Inpatient

A patient admitted to a Hospital or other facility for bed occupancy to receive services consisting of active medical and nursing care to treat conditions requiring continuous nursing intervention of such an intensity that it cannot be safely or effectively provided in any other setting.

Institutional Provider

This is a hospital, medical care facility, or ambulatory surgical center.

Insured

International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM)

ICD-9-CM is a comprehensive list of diagnosis codes and narrative. ICD-9-CM is based on the International Classification of Diseases, 9th Revision; Clinical Modification codes and instructions; as well as Medicare regulations and manuals issued by the Centers for Medicare & Medicaid Services (CMS) and by the Health Care Financing Administration (HCFA). Diagnosis is required on Blue Cross and Blue Shield of Kansas claims.

M

Medical Care Facility

This is a facility that is not a hospital (see definition) but that is:

- an alcoholic treatment facility;
- a drug abuse treatment facility; or
- a community mental health center.

To qualify as a Medical Care Facility, the facility must also be licensed by the State of Kansas to provide diagnosis and/or treatment of a nervous or mental condition.

Medical Emergency

This means a sudden and, at the time, unexpected onset of a health condition that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Medical Necessary

Medical necessary means a service required to diagnosis or to treat an illness or injury. To be medically necessary, the service must: be performed or prescribed by a doctor; be consistent with the diagnosis and treatment of the condition; be in accordance with standards of good

medical practice; not be for the convenience of the patient or the doctor; and is provide in the most appropriate setting.

Medicare Crossover

The Crossover Program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payer with Medicare's supplemental insurance company.

Medicare Severity – Diagnostic Related Grouping (MS-DRG)

A grouping of disease and disorders put into medically meaningful sets as developed by the Centers for Medicare & Medicaid Services (CMS). This reimbursement system consists of established payment levels for groupings of patients according to medically meaningful characteristics. There are six major criteria, which are utilized in assigning a particular admission to a specific DRG. These consist of:

- Patient's principal diagnosis
- Procedures performed on the patient
- Patient's age
- Patient's gender
- Patient's discharge status
- Multiple diagnoses, complications or comorbid conditions.

Blue Cross and Blue Shield of Kansas (BCBSKS) has always utilized the standard Medicare grouper for establishing the maximum allowable payment (MAP) for inpatient claims. So, when Medicare decided to move towards the MS-DRGs, BCBSKS followed and established their MAPs based on the MS-DRG grouper.

[Medicare Summary Notice \(MSN\)](#)

[Medicare Supplement \(Medigap\)](#)

[Member](#)

N

National Account

An employer group that has offices or branches in more than one location but offers uniform coverage benefits to all of its employees.

National Provider Identifier (NPI)

The NPI is ten-digit number and is used to submit claim transactions to all government and non-government payers. NPI replaced existing provider numbers assigned by these entities.

National Uniform Billing Committee (NUBC)

A group representing hospitals and payers in the discussion and resolution of billing issues for health care institutional services. The NUBC administers the UB-04 institutional claim form.

Nervous and Mental Condition

Means a disorder specified in the Diagnostic and Statistical Manual of the American Psychiatric Association but exclusive of those shown as not attributed to a mental disorder that are a focus of attention to treatment.

Non-Biologically Based Nervous or Mental Condition

Means a condition which is a nervous or mental condition but is not a biologically based nervous or mental condition.

Notice of Personal Financial Obligation (NOPFO)

Providers cannot bill Blue Cross and Blue Shield of Kansas members for services that have been determined medically unnecessary or experimental/investigational unless the member has been given written notification in advance of receiving the service that they will be responsible. All claims for services that are medically unnecessary or experimental/investigational must be submitted to BCBSKS with a copy of the Notice of Personal Financial Obligation.

No-fault Motor Vehicle Insurance

Non-Contracting Provider

O

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.

Outlier

Patient stays that have unique characteristics and are considered to be outside established parameters for each DRG. Outliers consist of cases with any of the following characteristics:

1. Length of stay above or below specified trim points
2. Patients leaving against medical advice
3. Transfers of patients to other hospitals.
4. Patients having unrelated conditions treated during hospitalization (DRG codes 468-470)
5. Prior to 1998 dates of service, deaths were also considered an outlier.

Outpatient

A person treated in the outpatient department or emergency room of a Hospital, or in a free-standing Ambulatory Surgical Facility, or a Physician's office – a person not admitted for Inpatient treatment.

P

Palliative Care

Treatment directed at controlling pain, relieving other physical and emotional symptoms and focusing on the special needs of the hospice patient and the hospice patient's family, as they experience the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

Partial Hospital Program (PHP)

An intermediate level of care for mental illness. Partial hospitalization programs (PHP) are full day programs within a psychiatric hospital or behavioral health department of a hospital.

Per Diem Rate

A form of payment for services in which the provider is paid a daily fee for specific services, regardless of the cost of provision.

Plan

A Plan refers to any Blue Cross and/or Blue Shield Plan.

Point of Service

Precertification

Pre-Existing Condition

Present On Admission (POA)

Present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery are considered present on admission.

Principal Diagnosis

The condition which is determined to be the primary reason for treatment.

Principal Procedure

The procedure performed for definitive treatment, rather than for diagnostic or exploratory purposes, or to resolve a complication. More than one procedure may meet this definition and may be listed on the claim.

Provider Discounts

R

Rehabilitation Services

Means therapies that when provided in an inpatient or outpatient setting, are designed to restore physical functions following an accidental injury or and illness.

Remittance Advice (RA)

The BCBSKS claim payment report for participating Hospitals, Physicians and other providers of health care services. The RA is a record of how payment was made: total Charges, Covered Person's liability, Provider liability, and BCBSKS payment.

Research-Urgent

Means a drug, device, medical treatment or procedure that is otherwise excluded (see Glossary – Experimental or Investigational) but meets the following criteria:

1. Is a therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is either life threatening or severely and chronically disabling and that has a poor prognosis with the most effective conventional treatment.
2. There is credible evidence that the treatment may provide a clinically significant and substantial improvement in net health outcome compared to the most effective conventional treatment, or where conventional treatment has failed or is not medically appropriate.

3. Regardless of funding source, the drug, device, medical treatment or procedure is available to the patient seeking it and will be provided within a well designed clinical trial conducted by the National Institute of Health, Inc. or by an institution or entity which the protocol for the drug, device, medical treatment or procedure has been approved by the an Institutional Review Board that is in compliance with the ethical principles in: (a) The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research or the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, or (b) other appropriate ethical standards recognized by Federal Departments and Agencies that have adopted the Federal Policy for the Protection of Human Subjects.
4. The drug, devise, medical treatment or procedure is not available free or at a reduced cost.

Revenue Code

A three-digit code that identifies a specific accommodation, ancillary service or billing calculation related to the service being billed.

Ridered Condition

A ridered condition (restricted condition) is an illness or condition for which **any type of treatment or care is EXCLUDED** from otherwise eligible BCBSKS benefits.

S

Service Area

The geographic area in which a Licensee is authorized to use the Brands pursuant to the primary Blue Cross and/or Blue Shield License Agreement or to the Blue Cross and/or Blue Shield Controlled Affiliate License Agreement.

Subrogation

Subrogation is our right to recover benefits paid for Covered Services as the result of an Injury or Illness which was caused by a third party. We also assert a contractual right of recovery to collect proceeds recovered from a third party. Subrogation and the contractual right of recovery are prior liens against any proceeds recovered by the Covered Person.

Suitcase Logo

The BCBSA branded trademark for the BlueCard Program.

[Summary of Claims Processed \(SOCP\)](#)

Swingbed

Means a skilled nursing facility bed in a hospital, which allows for patients to stay for an extended period of time due to their needs for further medical services past their initial hospital admission.

T

Tax Identification Number (TIN)

The TIN is the number you use to file income tax with the IRS.

[Traditional](#)

U

UB-04

The Uniform Bill UB-92 is intended to be used by the major Third Party Payers, most Hospitals and nursing homes. The data elements and design of the form are determined by the National Uniform Billing Committee. The NUBC has developed uniform definitions and procedures for completing

the form. The procedural guidelines are designed to provide actual completion instructions for each payer.

Utilization Review

Means a claims review process of medical necessity and includes review of: the need for inpatient admissions; the appropriateness of the patient's length of stay; the appropriate use of tests and procedures in relation to the diagnosis and treatment of the patient's condition.

W

[Waiting Period](#)

[Workers' Compensation](#)