BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Glossary of Terms

Term	Definition
Abuse	An act that may not have all the elements of fraud, but it takes advantage of a situation and results in an unauthorized benefit. The person more than likely has taken advantage of an "accepted practice" or has found a "loophole" to obtain a benefit for which they are not entitled.
Accreditation	An evaluative process and examination of procedures that a healthcare organization undergoes 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.
Adverse Event	Any harm a patient suffers that is caused by factors other than the patient's underlying condition.
Alabama Health Improvement Initiative (AHII)	AHII is Blue Cross and Blue Shield of Alabama's physician quality and rewards programs.
Allowed Charge	The amount considered for payment based on the services billed and the member's benefits. The allowed amount for a network provider and non-network provider is the applicable fee schedule amount for a particular service. For a network provider, anything charged over the allowed amount is a provider write off. For non-network providers, charge amounts over the allowed amount are the member's liability.
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.
American National Standards Institute (ANSI)	ANSI establishes standards and procedures in the computing industry for many different businesses. ANSI is also the specific type of format selected as the standard for HIPAA (see definition below) covered transactions.
Assignment	When a provider agrees to accept payment from the insurance carrier for services rendered on behalf of the patient. Payments go directly to the provider. Participating providers must accept assignment.
Assistant Surgeon	A registered medical physician who aids a surgeon in performing surgeries.
Audit Report	A report that lets the provider or practice management software vendor know whether electronic claims have been accepted for processing in the Blue Cross and Blue Shield of Alabama system or rejected due to errors. Claims rejected on this report need to be refiled as new claims with corrected information.
Benefit	Coverage for services available to a member as defined in their insurance certificate.
Benefit Period	A time span during which benefits may be provided. While the benefit period is usually a set unit of time, such as a year, benefits may also be tied to a specific illness.
Blue Advantage®	Blue Cross and Blue Shield of Alabama's Medicare Advantage Plan.
BlueCard®	BlueCard is a national program that enables members of one Blue Cross Plan to obtain healthcare services while traveling or living in another Blue Cross Plan's service area. The program links participating healthcare providers with the independent Blue Cross Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.
BlueCard® Access®	A toll-free number, 800-810-BLUE (2583), for providers and members to use to locate healthcare providers in another Blue Cross Plan's area. This number is useful when you need to refer a patient to a physician or healthcare facility in another location.
BlueCard® Doctor and Hospital Finder	An online provider directory available through the Blue Cross and Blue Shield Association's website, **bcbs.com**, used to locate healthcare providers in another Blue Cross Plan's area. This directory can also be accessed through Blue Cross and Blue Shield of Alabama's website, **AlabamaBlue.com**.

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BlueCard® Eligibility®	A toll-free number, 800-676-BLUE (2583), for verifying membership and coverage information for patients from other Blue Cross and Blue Shield Plans.
BlueCard® Worldwide®	A program that allows Blue Cross and Blue Shield members traveling or living abroad to receive services from participating healthcare providers worldwide. The program also allows members of foreign Blue Cross and Blue Shield Plans to access Blue Cross and Blue Shield provider networks in the United States.
C Plus SM	C Plus is Blue Cross and Blue Shield of Alabama's Medicare Select Plan B Supplement Plan.
Capitation	A method of paying for healthcare services at a flat rate based on the number of patients who are covered rather than the cost or number of services that are actually provided.
Case Management	A process of identifying members with special healthcare needs, developing a healthcare strategy that meets those needs, and coordinating and monitoring care.
Centers for Medicare & Medicaid Services (CMS)	The Department of Health and Human Services agency responsible for Medicare and parts of Medicaid. Previously, known as the Health Care Financing Administration (HCFA).
Claim	An itemized statement of healthcare services and their costs. Claims are submitted to the insurer by the plan member or the provider for payment of costs incurred.
Coinsurance	A provision in a member's benefit plan that limits the amount of coverage to a certain percentage. Any additional costs are paid by the member.
Consumer Directed Healthcare/Driven Health Plan (CDHC/CDHP)	CDHC is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. High Deductible Health Plan, Health Savings Account, Health Reimbursement Arrangement and Flexible Spending Accounts are terms associated with CDHC. These arrangements play a potential role in the design and delivery of benefits through CDHPs. CDHPs provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information, and financial incentives.
Contract	A written agreement between Blue Cross and a member or a provider.
Contract Maximum	The total number of services allowed or amount paid within a benefit period.
Coordination of Benefits	Coordination of payment when a member is covered under more than one health insurance plan.
Copayment	A specified charge that a member must pay out of pocket for a specified service at the time the service is rendered.
Corrected Claim	Corrected claims are filed when changing, adding or deleting the diagnosis code, procedure code, patient or charge amount on a claim that has already been **paid/ finalized** and returned on a remittance advice. The original claim number obtained from the remittance advice must be submitted with the corrected claim. If the previously submitted claim has been **non-covered** on the remittance advice, submit a **new** claim with the updated information, not a corrected claim.
Coverage	The extent of benefits provided by a member's contract.
Current Procedural Terminology (CPT)	Physicians' Current Procedural Terminology (CPT) is a national uniform numeric coding system that lists descriptive terms and identifying codes for reporting medical services and procedures performed by physicians to assure consistency in coding claims.
Deductible	An amount the member must meet before the insurer will make any benefit payments.
Dependent	Any member on the contract other than the subscriber.
Disease Management	A coordinated system of preventative, diagnostic and therapeutic measures intended to provide cost-effective, quality healthcare for a patient population that has or is at risk for a specific chronic illness or medical condition.
eClaims	*ProviderAccess* function for claims entry.
Effective Date	The date insurance coverage begins.

Term	Definition
Electronic Data Interchange (EDI)	EDI refers to the use of electronic transactions for exchanging patient and claim information between Blue Cross and Blue Shield of Alabama and affiliated providers. The Blue Cross electronic information network, known as e-Practice Management (E-PM), offers electronic connections for EDI transactions through various Practice Management software systems and the Blue Cross *ProviderAccess* web application.
Electronic Funds Transfer (EFT)	EFT is the direct deposit of provider payrolls into a bank account.
Electronic Medical Record (EMR)	An electronic medical record (EMR) is a computerized record of a patient's clinical, demographic and administrative data. Also known as a computerbased patient record.
Electronic Transactions	There are two types of electronic transactions regarding the exchange of patient and claim information with Blue Cross. Health Insurance Portability and Accountability Act (HIPAA) standard electronic transactions between covered entities and proprietary transactions not covered under HIPAA. The **837** is the electronic file for professional, institutional or dental healthcare claims transactions. The **835** is the electronic file for a remittance advice. The **270** is the electronic inquiry for eligibility and benefit information and the **271** is the electronic response. The 271 contains the current status of a patient's eligibility and benefits information. The **276** is the electronic request for claim status information and the **277** is the electronic response. The 277 contains the current status of a pending or finalized claim. The **278** is the electronic referral or precertification request. Proprietary transactions contain data that cannot be supported in a HIPAA mandated transaction such as payment history or summary plan descriptions.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.
Employee Retirement Income Security Act (ERISA)	ERISA is a broad-reaching law that establishes the rights of pension plan participants, standards for the investment of pension plan assets, and requirements for the disclosure of plan provisions and funding.
Endorsement	A provision added to a member's contract that changes the scope of coverage.
Exclusions	Specified conditions for which a member's contract will not provide benefits.
Expanded Psychiatric Services (EPS)	A capitated plan that provides 100 percent coverage for mental health and chemical dependency services when the member uses a participating psychiatric provider for care and treatment.
Explanation of Benefits	A statement sent to a member or provider that explains action taken on each claim.
Federal Employee Program (FEP)	FEP is a group healthcare program designed for federal employees and their dependents.
File Transfer Protocol (FTP)	The method used to exchange files (i.e., claims, remittances and audit reports) electronically with Blue Cross.
Filing Limitation	A timely filing provision that requires claims to be received for payment for services that were rendered or expenses incurred within a certain time frame from the date of service.
Flexible Spending Account (FSA)	An FSA is an account used by members to pay for healthcare expenses not covered by their health or dental insurance. Members may use pre-tax payroll deductions to set aside cash for these expenses. The Internal Revenue Service defines eligible medical care expenses as, "amounts paid for the diagnosis, care, mitigation, treatment or prevention of disease or illness and for treatments affecting any part or function of the body."

Term	Definition
Formulary	A specific list of drugs that are included with a given plan for our members. A continually updated list of medications, related products and information, representing the clinical judgement of physicians, pharmacists, and other experts in the diagnosis and/or treatment of disease and promotion of health.
Fraud	The intentional deception, concealment or misrepresentation that an individual or entity makes, knowing that the misrepresentation could bring some benefit to them or another party that they are not legally entitled to receive.
Group	A business or organization that has a contract with Blue Cross and Blue Shield of Alabama to provide a benefits plan for its employees or members.
Group Number	A common identification number assigned to all covered individuals in a group.
Health Care Financing Administration (HCFA)	HCFA is the previous name of the entity that is now known as the Centers for Medicare & Medicaid Services (CMS).
Health Insurance Portability and Accountability Act (HIPAA) of 1996	Under the Administrative Simplification provision (Title II) of HIPAA, the Department of Health and Human Services has established national standards for electronic healthcare transactions and national identifiers for providers, health plans and employers. It also addresses the security and privacy of electronic health information.
Health Level 7 (HL7)	Health Level 7 is an ANSI accredited standards organization that publishes specifications for the electronic exchange of relevant medical information among independent healthcare-oriented systems.
Healthcare Common Procedure Coding System (HCPCS)	HCPCS is a structured coding system that includes American Medical Association (AMA) CPT codes supplemented by national CMS-assigned and local carrier assigned codes. HCPCS codes and modifiers may contain alphabetic characters.
Hold Harmless Provision	An agreement with a provider not to bill a member for any difference between billed charges for covered services (excluding coinsurance) and the amount the provider has contractually agreed with Blue Cross as full payment for those services.
Home Plan	The Blue Cross Plan that holds the member's contract.
Host Plan	The Blue Cross Plan that is associated with the provider's service area.
Identification Card	Card issued to members giving the subscriber's name and the contract number to be used for filing claims.
Institutional Claims	Inpatient and outpatient hospital or facility claims.
Interactive Voice Response (IVR)	A system that uses a computer to accommodate the needs of a caller. The IVR may provide the assistance needed or transfer the caller to the appropriate area.
International Classification of Diseases-9th Revision-Clinical Modification (ICD-9-CM)	ICD-9-CM is a coding system used to identify a patient's diagnosis or nature of illness or injury. ICD-9-CM codes contain up to five digits.
ICD-10-CM	Classification of Diseases, Tenth Revision, Clinical Modification
ICD-10-PCS	Classification of Diseases, Tenth Revision, Procedure Coding System
Julian Date	A number that represents the day of the year. For example: January 1 = 001 and December 31 = 365 The Julian Date is used in all claim numbers to denote when a claim was accepted for processing (e.g., 560-**123**456789). The "123" numbers denotes that the claim was accepted for processing on May 3.
Limiting Charge	Medicare's limit on the amount a non-participating provider can charge a beneficiary for services provided.
Locum Tenens	A physician who works in the place of the regular physician when that physician is on holiday or ill.
Long-Term Care	Services required by persons who are chronically ill, aged physically or mentally disabled. This type of care is provided in the person's residence, whether at home or in an institution.

Term	Definition
Medical Emergency	A sudden unexpected illness that is severe enough to require immediate medical care.
Medicare Advantage	Medicare Advantage plans give Medicare beneficiaries an option to receive their Medicare benefits through private health insurance plans instead of through Original Medicare (Parts A and B).
Member	An individual (employee or dependent) covered under a contract.
Mental Health Parity Act (MHPA)	A law that prohibits group health plans from applying more restrictive annual and lifetime limits on coverage for mental illness than for physical illness.
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.
National Correct Coding Initiative (NCCI)	The NCCI is a nationally recognized and widely used standard for editing claims to ensure accurate coding and reporting of services.
National Practitioner Data Bank (NPDB)	A database maintained by the federal government that contains information on physicians and other medical practitioners against who medical malpractice claims have been settled or other disciplinary actions have been taken.
National Provider Identifier (NPI)	NPI is a national provider identifier required by HIPAA legislation. NPIs uniquely identify all providers of healthcare services, supplies and equipment. NPIs are assigned by the National Plan and Provider Enumeration System (NPPES) and are 10-position, all numeric identification numbers that identify a healthcare provider in HIPAA standard transactions, such as healthcare claims. There are two types of NPIs: Individual NPIs and Organizational NPIs. An **Individual** NPI is assigned to a person and there is only one Individual NPI assigned to that person. An **Organizational** NPI belongs to a non-person provider such as a hospital, supplier of durable medical equipment, incorporated provider practice, pharmacies and any "subpart" of those organizations. A **Payee** NPI refers to the NPI a provider has selected to receive payment. The Payee NPI can be an Individual NPI or an Organizational NPI. The appropriate Payee NPI is established during the provider enrollment/credentialing process.
Non-Assignment	A payment method used when a provider chooses not to accept payments directly from the payer. Participating providers must accept assignment.
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 physician.
Out of Pocket	Money a member has to pay out of his/her own pocket for particular healthcare services during a particular time period based on the member's benefits.
Outcome Measures	Healthcare quality indicators that qualify the extent to which healthcare services succeed in improving or maintaining satisfaction and patient health.
Payment	The amount paid to a provider or member for services rendered.
Peer Review	A process where healthcare services delivered by a provider are evaluated by a panel of medical professionals for appropriate level of care.
Plan	Refers to any Blue Cross and/or Blue Shield Plan. For example, Blue Cross and Blue Shield of Alabama is a Plan.
Preadmission Certification	A program designed to assure members in advance that a hospital inpatient admission is medically necessary. Also, known as a precertification.
Precertification	A utilization management technique that requires a plan member or the physician in charge of the member's care to notify the plan, in advance, of plans for a patient to undergo a course of care such as a hospital admission or complex diagnostic test. Also known as prior authorization.
Predetermination	Predetermination is a courtesy pre-review of services that are possibly non-covered by an insurance carrier.
Pre-Existing Condition	A condition that exists/existed prior to the effective date of the contract.

Term	Definition
Professional Claims	An itemized statement of healthcare services and their costs filed by a physician, supplier or other healthcare provider (non-institutional).
Provider	An institution, individual or organization that provides healthcare services or supplies.
ProviderAccess	Blue Cross and Blue Shield of Alabama's online web portal for healthcare providers available through our website, **AlabamaBlue.com**.
Provider Profiling	The collection and analysis of information about the practice patterns of individual providers.
Remittance	A report provided by Blue Cross that details claims payments and non-covered amounts. If a service is non-covered, the remittance advice provides an explanation. Electronic and online remittances are available on Mondays. Paper remittances are mailed on Thursdays.
Resource-Based Relative Value Scale (RBRVS)	RBRVS is a payment methodology used by insurers and is based on the principle that payments for physician services should vary with the resource costs for providing those services. RBRVS Methodology ranks services according to the relative cost required to provide that service and compares that service in relation to other services.
Return to Provider Report	A report returned to a provider listing paper claims that were not accepted for processing due to errors. Claims on this report need to be refiled as a new claim with corrected information. Paper claims are held to the same standards as electronic claims.
Riders	Additional coverage purchased by a group for its members.
Secondary Payer	When a member has two payers/contracts, the secondary payer administers benefits after the primary payer has completed processing.
Self-Funded Plan	A healthcare plan where an employer or other group sponsor, rather than the insurance company, is financially responsible for paying plan expenses and claims. Also known as self-insured.
Self-Insured Groups	A healthcare plan where employer groups determine their own benefit structure and pay for their own claims. The healthcare payer (Blue Cross) is the administrator of the plan.
State Children's Health Insurance Program (SCHIP)	A program, established by the Balanced Budget Act, designed to provide health assistance to uninsured, low-income children either through separate programs or through expanded eligibility under state Medicaid programs.
Subscriber	The person to whom the insurance contract is issued.
Subpart	A component of an organizational healthcare provider that is related but functions separately from a "parent" component. For example a hospital subpart could include outpatient departments, surgical centers, psychiatric units and laboratories.
Total Charge	The sum of the fees for all services rendered by a healthcare provider.
Underwritten Groups	A healthcare plan where the payer (Blue Cross) assumes the financial risk for the group, determines the benefit structure and pays claims out of premiums collected from the group.
Uniform Provider Application (UPA)	The UPA is an online form available for new providers that wish to be credentialed by Blue Cross and Blue Shield of Alabama. The UPA may be printed and used for other insurance carriers/insurers.
Waiting Periods	The time a person must wait after the effective date of the contract before benefits for pre-existing conditions are available.
Workers' Compensation	A state-mandated insurance program that provides benefits for healthcare costs and lost wages to qualified employees and their dependents if an employee suffers a work-related injury or disease.
AlabamaBlue.com	Blue Cross and Blue Shield Association's web site. This site contains useful information relative to the entire Blue Cross system. This web site contains information on the BlueCard program, national programs, consumer tools and much more. A national provider directory is also available.
AlabamaBlue.com/Providers	The provider pages of the Blue Cross and Blue Shield of Alabama website containing educational and informative information to assist the provider community with filing and coverage information, updates, medical policies, etc. Access to the local provider directory and the national directory are also available.