

Glossary of Terms

Abuse	An act that may not have all the elements of fraud, but that 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.
Alternate Billing	See EMC.
Application	A form completed by a person to apply for coverage.
Assignment	A payment method under medical insurance in which payment for covered services go directly to the provider.
Assistant Surgeon	A registered medical physician who aids a surgeon in performing an operation.
Benefits	Services, as defined in the insurance certificate, available to a member.
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. A benefit period is applicable to Blue Cross Hospital coverage, Blue Shield Medical, surgical and all other coverage not a part of hospital.
Claim	A request for payment under an insurance contract.
Coinsurance	A means of sharing, dividing or splitting the cost of services between the plan and the subscriber, usually represented in a percentage amount.
Contract	A written agreement between Blue Cross and a subscriber for specific coverage.
Contract Maximum	The total allowed to be paid within a benefit period for services rendered
Contract Number	A number assigned to each subscriber for identification purposes.
Conversion	A contract offered to members who leave a group and change to a direct pay contract.
Coordination of Benefits	The means by which benefits paid by one company are reduced because of other group coverage when a member is covered by more than one contract.
C Plus SM	A contract designed to supplement Medicare coverage
CPT	Physicians' <i>Current Procedural Terminology</i> 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.
Coverage	The extent of benefits provided by a subscriber's contract.
Customary Charge	The Blue Cross and Blue Shield of Alabama's customary charge is the 90th percentile of the range of usual charges for the same or a similar service billed

by most physicians with similar training and experience within the same geographic area.

Deductible	The amount to be paid by the subscriber first for a hospital admission or Major Medical claim during the calendar year before a contract will make benefit payments.
Dependent	A member covered under a subscriber's family contract such as a spouse or a child.
Direct Pay Contract	The premium is paid directly from the subscriber to Blue Cross.
DRG	Diagnosis related groups (DRGs) are a system for payment to hospitals for inpatient services under Medicare Part A and are based on prospectively set rates. Medicare payment is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of DRGs.
EDI	Electronic Data Interchange (EDI) refers to the use of electronic transactions for exchange patient and claim information between Blue Cross and Blue Shield of Alabama and our affiliated providers. The electronic information network of Blue Cross, known as e-Practice Management (e-PM), offers electronic connections for EDI transactions through various Practice Management software systems, the PCEMC+ software, and our online web site applications.
Effective Date	The date coverage begins.
EMC	Electronic Media Claims (EMC) refers to the electronic transmission of medical claims.
e-PM	e-Practice Management (e-PM) is the electronic information network of Blue Cross offering electronic connections for EDI transactions through various Practice Management software systems, the PCEMC+ software, and our online web site applications.
Endorsement	A provision added to a subscriber's contract that changes the scope of its coverage
Exclusions	Specified conditions for which a subscriber's contract will not provide benefits
Explanation of Benefits	A computer-written statement sent to a subscriber or provider that explains action taken on each claim.
FEP	Federal Employee Program (FEP) is a group health care program designed for federal employees and their dependents.
Filing Limitation	A timely filing provision that requires that claims must be received for payment for services that were rendered or expenses incurred within a certain timeframe from the date of service.
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.
HCFA	Health Care Financing Administration – this is the previous name of the entity that is now known as the Centers for Medicare and Medicaid Services (CMS).
HCPCS	HCFA Common Procedure Coding System (HCPCS) is a structured coding system that includes American Medical Association (AMA) CPT codes supplemented by nationally HCFA-assigned and local carrier assigned codes. Unlike CPT, the HCPCS codes and modifiers may contain alphabetic characters.
HIPAA	Health Insurance Portability and Accountability Act (HIPAA) of 1996 - Under the Administrative Simplification provisions (Title II) of HIPAA, the Department of Health and Human Services has established national standards for electronic health care transactions and national identifiers for providers, health plans and employers. It also addresses the security and privacy of electronic health information.
HMO	A Health Maintenance Organization (HMO) is a health care 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.
Home Plan	The Blue Cross Plan providers or subscribers send claims to when the subscriber receives medical care in a different Plan's geographic area. A group's Home Plan is the Plan that has control of the group.
Host Plan	The Blue Cross Plan associated with the provider that furnishes services to a subscriber from a different Plan. It is a Plan that helps the Home Plan service the group.
ICD-9-CM	The <i>International Classification of Diseases-9th Revision-Clinical Modification</i> is a coding system that is used to identify a patient's diagnosis or nature of illness or injury. The codes contain up to five digits. Codes beginning with E or M should not be used filing claims.
Identification Card	Card issued to each subscriber giving his/her name, coverage, effective date of current coverage, and waiting period information.
Indemnity	A fixed dollar payment for a specified health care service.
Julian Date	A number that represents the day of the year, for example: <i>January 1 = 001 December 31 = 365.</i> This number is used on claims to show the date of receipt, for example: <i>Blue Cross physician claim 555-0096865 represents January 9.</i>
Medicare Advantage	The name for Medicare + Choice plans. If you have one of these plans, you don't need a Medigap policy. The Medicare Advantage plan that Blue Cross offers is called BlueAdvantage.

Major Medical	Coverage for physician services and other covered medical expenses. At Blue Cross and Blue Shield of Alabama, the term refers to coverage to supplement Blue Cross (hospital) or Blue Shield (physician) benefits. Examples of services typically covered under Major Medical include prescription drugs, Durable Medical Equipment (DME), ambulance service, and mental and nervous services.
Maximum Allowance	The maximum dollar amount that a health plan will pay toward the cost of a service.
Medical Emergency	A sudden and unexpected illness which is severe enough to require immediate medical care.
Member	An individual (employee or dependent) covered under a contract.
Non-Assignment	When a physician chooses not to accept payments directly from the carrier (Blue Cross). Participating providers must accept assignment.
Non-covered charges	Charges for items not covered under a health insurance contract.
Non-Participating	A provider that does not have a signed contract with Blue Cross agreeing to the conditions of one or more of our participating networks, or when a network is not available for that specialty. Also referred to as Non-PAR providers. Non-PAR providers may or may not choose assignment when submitting a claim and may collect their charges from the subscriber since the subscriber is ultimately responsible for payment.
NPI	The national provider number (NPI) is a national provider identifier required per HIPAA legislation.
Participating	A provider that participates in one of the many networks Blue Cross offers (PMD, Radiology, Physical Therapy, Primary Care, etc.) The participating provider signs a contract to accept assignment for all services provided to our subscribers and also agrees to accept the fee schedule amount as payment in full for the covered services. Also referred to as PAR providers.
Payer	An entity that reimburses health care claims such as Blue Cross and Medicare.
Payment	The amount paid to the provider for services rendered.
PCEMC+	Personal Computer Electronic Media Claims Plus (PCEMC+) is a Windows-based application developed by Blue Cross and Blue Shield of Alabama. The PCEMC+ software offers a provider the capability to enter and transmit in an electronic file to Blue Cross. It also offers electronic access to patient account and claim/payment information.
Per Diem	Usually refers to hospital reimbursements that are paid according to a daily rate.
Plan	Blue Cross and Blue Shield of Alabama or the benefits offered under a health benefits contract.
Plan Code	First three digits of the eight-digit provider number

PPO	A Preferred Provider Organization (PPO) is a system of health care organized by an insurance company for groups. Physicians, health care providers of all types including hospitals and clinics sign contracts with the PPO system to provide care to its insured people. These medical providers accept the PPO's fee schedule and guidelines for its managed medical care.
Preadmission Certification	A program designed to assure members in advance that a hospital inpatient admission is medically necessary. Also called a percent.
Pre-Existing Condition	A condition that existed/exists prior to the effective date of the contract.
Primary Care Network	A network of physicians who participate in Blue Cross and Blue Shield of Alabama's point of service product.
Provider	An institution, individual, or organization/business that provides health care services and/or supplies.
Provider Number	The identifying number assigned to a physician by a payer for filing claims. Also referred to as a legacy number.
Riders	Coverage purchased by a group to provide additional benefits.
Secondary Carrier	The contract which pays the balance (or up to contract limits) when a member has two contracts and primary benefits are provided by the other contract.
Subscriber	The person to whom a contract is issued
Total Charge	The total charge submitted by the provider
UCR	The usual, customary, and reasonable (UCR) fee is the amount of a physician's charge that Blue Shield will recognize for payment for his/her medically necessary services covered by a subscriber's contract.
VRU	A voice response unit is an automated response telephone line used to request information.
Waiting Periods	The time a person must wait after the effective date of the contract before benefits for pre-existing conditions are available.
Waivers	No waiting periods for preexisting conditions are set on a contract.