

Health Care Terminology Glossary

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AAHCC - American Accreditation Health Care Commission - AAHCC accreditation is an important quality "seal of approval" for provider networks and managed care organizations. Gaining accreditation requires meeting standards for confidentiality, staff qualifications and credentials, program qualifications, quality improvement programs, accessibility and on-site review procedures, information requirements, utilization review procedures and appeals.

Academic Medical Center (AMC) – A partnership uniting a medical school, a hospital, and physician groups for the purpose of educating and training medical students, as well as conducting research.

Access – A patient's ability to obtain medical care determined by factors such as the availability of medical services, their acceptability to the patient, the location of health care facilities, transportation, hours of operation, and cost of care.

Accident and Sickness – Coverage for short term income replacement when the covered person is disabled because of an accident or illness. Same as weekly indemnity, weekly disability, and short term disability.

Accidental Death and Dismemberment – Insurance providing a benefit if the insured person dies by accidental means or accidentally loses certain specified body parts (leg, arm, etc.).

Accountable Health Plan (AHP) – Under the Managed Competition Act, providers and insurance companies would be encouraged (through tax incentives) to form AHPs, similar to HMOs, PPOs, and other group practices. AHPs would compete on the basis of offering high-quality, low-cost care and would offer insurance and health care as a single product. They would be responsible for looking after the total health of members and reporting medical outcomes in accordance with federal guidelines.

Accreditation – The granting of approval given by a credible organization, of the processes, policies and procedures utilized by the entity seeking such approval. Various organizations in the healthcare industry grant accreditation's, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Activities of Daily Living (ADL(s)) – An individual's daily habits such as bathing, dressing and eating. ADLs are often used as an assessment tool to determine an individual's ability to function at home, or in a less restricted environment of care.

Actual Use Effectiveness – The effectiveness of a product in real-life situations. Actual use effectiveness considers compliance rates, physical condition of the patient, and the side effects associated with the product's use.

Actuary – A person in the insurance field who decides insurance policy rates and reserves dividends as well as conducts various other statistical studies.

Acute Care – A pattern of health care in which a patient is treated for an acute (immediate and severe) episode of illness; for the subsequent treatment of injuries related to an accident or other trauma; or during recovery from surgery. Acute care is usually delivered in a hospital setting by specialized personnel using complex and sophisticated technical equipment and materials. Unlike chronic care, acute care is usually only delivered over a short time span of 30 days or less.

Acute Care Services – Coordinated services related to the examination, diagnosis, care, treatment, and disposition of acute episodes of illnesses.

Acute Disease – Disease characterized by a single episode of fairly short duration, usually less than 30 days, and from which the patient can be expected to return to his or her normal or previous state and level of activity.

Additional Diagnosis – Any diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the physician considers of sufficient significance to warrant inclusion for investigative medical studies.

Additional Drug Benefit List – Also called a drug maintenance list, the additional drug benefit list is a catalogue of pharmaceuticals approved by a managed health care plan for dispensing when drugs are prescribed other than those listed under the benefit package.

Adjudicate – The act of applying the provisions of a benefit plan to a claim.

Administrative Services Organization (ASO) – An arrangement under which an insurance company, for a fee, processes claims and handles paperwork for a self-funded group. This frequently includes all insurance company services (actuarial services, underwriting, benefit description, etc.) except assumption of risk.

Admission – The act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day on which the medical center or hospital makes a formal acceptance (assignment of a register number) of the patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients normally stay at least overnight. While the admission of a newborn is deemed to occur at the time of birth, live births are reported separately and excluded from admission data. Admission data include direct admissions, direct admissions from the emergency room and transfer-in patients from other medical treatment facilities; but exclude absent-sick patients, carded-for-the-record only (CRO) cases, and transient patients.

Admission Certification – A method of assuring that only those patients who need hospital care are admitted. Certification can be granted before admission (preadmission) or shortly after (concurrent). Length-of-stay for the patient's diagnosed problem is usually assigned upon admission under the certification program.

Advanced Practice Nurse (APN) – An umbrella term that describes a registered nurse (RN) who has met advanced educational and clinical practice requirements beyond the two to four years of basic nursing education required of all RNs.

Aftercare – Services that are administered after hospitalization or rehabilitation that are individualized .

Allied Health Personnel – Trained and licensed health workers other than physicians, dentists, optometrists, chiropractors, podiatrists, and nurses. The term is sometimes used synonymously with paramedical personnel, all health workers who perform tasks that must otherwise be performed by a physician, or health workers who do not usually engage in independent practice.

Allowable Charge – The maximum fee that a third party will reimburse a provider for a given service.

Allowable Costs – Items or elements of an institution's costs that are reimbursable under a payment formula. Allowable costs may exclude, for example, uncovered services, luxury accommodations, costs that are not reasonable, and expenditures that are unnecessary.

Alternative Birthing Center - A facility offering a "non-traditional" ("not like a hospital") setting for giving birth. These may range from a free-standing center to a special area within a hospital and are known for having a more comfortable, home-like atmosphere. More participation is allowed for the father and more procedural flexibility is allowed than in standard hospitals.

Alternate Care – Medical care received in lieu of inpatient hospitalization. Examples include outpatient surgery, home health care, and skilled nursing facility care. It also may refer to nontraditional care delivered by providers such as midwives.

Alternate Delivery Systems – Health services provided in other than an inpatient, acute-care hospital or private practice. Examples within general health services include skilled and intermediary nursing facilities, hospice programs, and home health care. Alternate delivery systems are designed to provide needed services in a more cost-effective manner. Most of the services provided by community mental health centers fall into this category.

Ambulatory Care – Health services delivered on an outpatient basis. If the patient makes the trip to the doctor's office or surgical center without an overnight stay, it is considered ambulatory care.

Ambulatory Setting – A type of health care setting where health services are provided on an outpatient basis. Ambulatory settings usually include physicians' offices, clinics, and surgery centers.

Ancillary Care – Additional health care services performed, such as lab work and x-rays.

Ancillary Services (Ancillary Charges) – Supplemental services, including laboratory, radiology, physical therapy and inhalation therapy that are provided in conjunction with medical or hospital care.

Anniversary Date – The day after a coverage period ends under a health benefits plan. Usually, the month and day that a health benefits plan first goes into effect becomes its anniversary date each year.

Appropriateness – Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment. Usually, appropriateness is determined through the use of Clinical Guidelines or Criteria that have been developed specifically for the purpose of determining the appropriateness and medical necessity of the treatment being requested.

Assessment – Diagnostic procedures, history, physical services and tests for the purpose of determining whether or not an eligible Insured is an appropriate candidate for specified healthcare services.

Assignment of Benefits – When a covered person authorizes his or her health benefits plan to directly pay a health care provider for covered services.

Attending Physician – 1) The physician with defined clinical privileges who has the primary responsibility for diagnosis and treatment of the patient. 2) A physician with privileges to practice the specialty independently. The physician may have either primary or consulting responsibilities depending on the case.

Authorization – As it applies to managed care, authorization is the approval of care, such as hospitalization. Pre-authorization may be required before admission takes place or care is given by non-HMO providers.

Avoidable Hospital Condition – Medical diagnosis for which hospitalization could have been avoided if ambulatory care had been provided in a timely and efficient manner.

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Behavioral Health Care – Treatment of mental health and/or substance abuse disorders.

Beneficiary – A person who is eligible to receive insurance benefits.

Benefit Bank – A flexible spending arrangement under which a reimbursement account is established. Reimbursements are made from the account, and the employee is entitled to any remaining amounts at the end of the year.

Benefit Levels – The limit or degree of service a person is entitled to receive based on his or her contract with a health plan or insurer.

Benefit Package - A term used to refer to the employer's benefits plan or to the benefits plan options from which the employee can choose.

Benefit Plan Summary – The description of employee benefits required to be distributed to the employees by ERISA. A synopsis of the benefits, usually in simple language, which does not include all the details of the plan.

Benefit Year – The coverage period, usually 12 months long, which is used for administration of a health benefits plan.

Benefits – Benefits are specific areas of Plan coverage(s), i.e., outpatient visits, hospitalization and so forth, that make up the range of medical services that a payer markets to its subscribers. Also, a contractual agreement specified in an Evidence of Coverage, determining covered services provided by insurers to members.

Benefits Manager – An individual in an organization responsible for managing the benefits program.

Billed Charges – The actual dollar amount billed by a doctor or other provider of healthcare services for a particular service.

Board-Certified – A physician who has passed an examination given by a medical specialty board.

Board Eligible – A physician who has graduated from an approved medical school and is eligible to take a specialty board examination.

Brand-Name Drug – A drug manufactured by a pharmaceutical company which has chosen to patent the drug's formula and register its brand name.

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Cafeteria Plan – A corporate benefits plan under which employees are permitted to choose among two or more benefits that consist of cash and certain qualified benefits. Cafeteria plans are also called flexible plans or flex plans.

Calendar Year – The period of time from January 1 of any year through December 31 of the same year, inclusive. Most often used in connection with deductible amount provisions of major medical plans providing benefits for expenses incurred within the calendar year.

Call Schedule – The schedule for physician availability for after-hours care.

Care Management – Sometimes less appropriately called case management or utilization management. Helps achieve better health outcomes by anticipating and linking patients with the services they need more quickly. Care management also helps to avoid unnecessary testing and care by preventing medical problems from escalating.

Care Paths – Set forth the steps that should be taken to assure an optimal outcome for the patient based upon the diagnosis and other factors set forth in the care plan.

Care Plan – A plan-of-care developed from the assessment of the patient and his/her diagnosis. The care plan takes into consideration items such as; living conditions and other situations with the potential to affect the outcome of the treatment plan.

Carrier – Refers to the party responsible for payment of a claim.

Carrier Replacement – A situation where a sole carrier replaces one or more other carriers on a specific group client. This allows consolidation of the group's experience and risk.

Case Management – The process whereby a health care professional supervises the administration of medical or ancillary services to a patient, typically one who has a catastrophic disorder or who is receiving mental health services. Case managers are thought to reduce the costs associated with the care of such patients, while providing high-quality medical services.

Catastrophic Health Insurance – Insurance beyond basic and major medical coverage for severe and prolonged illness, which poses the threat of financial ruin.

Centers of Excellence – A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein members access selected types of benefits through a specific network of medical centers.

Certification – A term used to signify the "approval" of services rendered. Many plans require that insureds call and obtain "certification" before receiving treatment.

Channeling – Use of incentives and plan design to encourage members to utilize network providers.

Chemical Dependency Services – Services and supplies used in the diagnosis and treatment of alcoholism, chemical dependency, and drug dependencies, as defined and classified by the U.S. Department of Health and Human Services.

Chemical Equivalents – Those multiple-source drug products containing essentially identical amounts of the same active ingredients, in equivalent dosage forms, and that meet existing physical/chemical standards.

Chronic Care – Long term care of individuals with long standing, persistent diseases or conditions. It includes care specific to the problem as well as other measures to encourage self-care, to promote health, and to prevent loss of function.

Chronic Disease – Disease that persists over a long period of time (i.e., more than 30 days), is not curable, and/or recurs frequently.

Claim – Information submitted by a provider or covered person to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made.

Claims Review – The method by which an enrollee's health care service claims are reviewed before reimbursement is made. The purpose of this monitoring system is to validate the medical appropriateness of the provided services and to be sure the cost of the service is not excessive.

Clinical or Critical Pathways – A "map" of preferred treatment/intervention activities. Outlines the types of information needed to make decisions, the timelines for applying that information, and what action needs to be taken by whom. Provides a way to monitor care "in real time." These pathways are developed by clinicians for specific diseases or events. Proactive providers are working now to develop these pathways for the majority of their interventions and developing the software capacity to distribute and store this information.

Clinical Practice Guidelines – General procedures and suggestions about what constitutes an acceptable range of practices for particular diseases or conditions. These guidelines are usually developed by a consensus of doctors in a given field, such as radiology or cardiology.

Closed Access – Gatekeeper model health plan that requires covered persons to receive care from providers within the plan's coverage. Except for emergencies, the patient may only be referred to and treated by providers within the plan.

Closed Panel – Medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed, but legally separate, medical group that only serves the HMO. This term usually refers to a group or staff HMO models.

Co-insurance – The percentage of the costs of medical services paid by the patient. This is a characteristic of indemnity insurance, POS and PPO plans. The coinsurance is usually about 20% of the cost of medical services after the deductible is paid.

Co-Morbid Condition – A medical condition that, along with the principal diagnosis, exists at admission and is expected to increase hospital length of stay by at least one day for most patients.

Co-Morbidity – A pre-existing condition on admission that will, because of its presence with a specific diagnosis, prolong the length of stay by at least one day in 75% of the patients.

Community Based Network – This vehicle provides coordinated, organized, and comprehensive care to a community's population. Hospitals, primary care physicians and specialists link preventive and treatment services through contractual and financial arrangements, producing a network which provides coordinated care with continuous monitoring of quality and accountability to the public. The Community Care Network tends to be community based and non-profit.

Complication – A medical condition that arises during a course of treatment and is expected to increase the length of stay by at least one day for most patients.

Computer-based Patient Record (CPR) – A term for the process of replacing the traditional paper-based chart through automated electronic means; generally includes the collection of patient-specific information from various supplemental treatment systems, i.e., a day program and a personal care provider; its display in graphical format; and its storage for individual and aggregate purposes. Also called Electronic Medical Record, On-Line Medical Report, and Paperless Patient Chart.

Comprehensive Care – The provision of a broad spectrum of health services that are required to prevent, diagnose, and treat physical and mental illnesses and to maintain health. Comprehensive care includes both physicians' services and hospitalization.

Comprehensive Medical Care Plans – Health plans that provide a wide range of care, including physicians' services in the home, in the office or clinic, and in the hospital.

Computerized Patient Record – An electronic system that enables practicing physicians and clinical staff to capture, store and communicate patient medical information.

Concurrent Review – A screening method by which a health care provider reviews a procedure or hospital admission performed by a colleague to assess its necessity.

Consultation – A discussion with another health care professional when additional feedback is needed during diagnosis or treatment. Usually, a consultation is by referral from a primary care physician.

Continuity of Care – The degree, to which the care of a patient from the onset of illness until its completion is continuous, that is without interruption.

Continuum of Care – Clinical services provided during a single inpatient hospitalization or for multiple conditions over a lifetime. It provides a basis for evaluating quality, cost, and utilization over the long term.

Conversion – An individual health policy issued to an employee or dependent leaving the group. The conversion policy is issued without regard to pre-existing conditions at appropriate rates. The benefits are generally very limited.

Co-Payment – What the insured may pay at the time of service. Copayments are predetermined fees for physician office visits, prescriptions or hospital services.

Cost Containment Guidelines – A listing of various requirements of a provider designed to keep the cost of providing healthcare services down, while not compromising the quality of care.

Coverage Status – The patient's status of coverage with their health care plan. The patient's status is either active (eligible) or inactive (terminated or ineligible) for coverage within a plan.

Coverage or Covered Services – Services provided within a given health care plan. Health care services provided or authorized by the payer's Medical Staff or payment for health care services.

Covered Benefit – A medically necessary service that is specifically provided for under the provisions of an Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.

Credentialing – Examination of a physician's or other health care provider's credentials to determine whether he or she should be entitled to clinical privileges at a hospital or to a contract with an MCO.

Critical Pathways – A schedule of critical care, medical and nursing procedure, including diagnostic tests, medications, consultations, designed to effect an efficient, coordinated program of treatment. Critical Pathways use a "best practice" standard approach identified as the most efficient and effective way to treat the diagnosis. The pathway includes data gathering concerning utilization, process compliance, functional goal achievement and identifies outliers.

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Data Retrieval – The collection of patient care data from medical records.

Day Outlier – A patient with an atypically long length of stay compared with other patients in a particular diagnosis related group.

Deductible – A fixed dollar amount an insured must pay out of his/her pocket before their insurance begins paying for services rendered.

Deficit – The decreased functionality of the affected body system as compared to a normal functioning system.

Demand Management – In its most basic form, demand management is the appropriate use of decision and self-management support systems that enable health care consumers to make the best use of medical care. Demand management is information-based in that it recognizes that decision making is often influenced by factors other than information, such as personal experience, societal pressures, and cultural norms.

Denials – Occurs when, during the course of reviewing a patient's treatment, the medical necessity cannot be validated based upon clinical guidelines or due to lack of information provided by the treating provider.

Dependent – An individual who receives health insurance through a spouse, parent, or other family member.

Detoxification – Medical supervision while an individual withdraws from alcohol or other addictive substances.

Diagnosis – The identification of a disease or condition through examination.

Disability – Any medical condition that results in functional limitations that interfere with an individual's ability to perform his or her normal work and results in limitations in major life activities.

Disallowance – A denial by a health care payer for portions of the claimed amount. Examples could include coordination of benefits, services that are not covered, or amounts over the fee maximum.

Discharge Planning – Required by Medicare and JCAHO for all hospital patients. A procedure where aftercare services are determined prior to discharge from the inpatient facility. Discharge planning is usually begun upon admission to the facility.

Disease Episode – The time period in which a person has specific disease or disorder.

Disease Management – A philosophy toward the treatment of the patient with an illness (usually chronic in nature) that seeks to prevent recurrence of symptoms, maintain high quality of life, and prevent future need for medical resources by using an integrated, comprehensive approach to health care. Pharmaceutical care, continuous quality improvement, practice guidelines, and case management all play key roles in this effort, which (in theory) will result in decreased health care costs as well.

Disease State – A medical condition that presents a specific group of symptoms, clinical signs, and laboratory assessments.

Disenrollment – The procedure of dismissing individuals or groups from their enrollment with a health carrier.

Drug Formulary – Varying list of prescription drugs approved by a given health plan for distribution to a covered person through specific pharmacies. (See also Formulary.)

Dual Choice – A term used to describe a situation in which only two carriers are contracted by a specific group. For example, an employer offers its employees one HMO and one indemnity plan, or two HMOs and no indemnity plan.

Duplicate Coverage Inquiry – A request to an insurance company or group medical plan by another insurance company or medical plan to find out whether other coverage exists for the purpose of coordination of benefits.

Duplication of Benefits – Overlapping or identical health coverage of an insured person under two or more plans, usually the result of contracts with different health organizations, insurance companies, or prepayment plans.

Durable Medical Equipment (DME) – Equipment that can be repeatedly used, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home.

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Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – A program which covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.

Economic Clinical Trials – Studies, usually conducted by pharmaceutical manufacturers, that evaluate drugs based on economic endpoints.

Eligible Covered Individual – Any person(s) entitled to receive services pursuant to participants benefit plan design, or an employee covered under participants worker's compensation program.

Eligible Dependent – Person entitled to receive health benefits from someone else's plan.

Eligible Employee – Employee who qualifies to receive benefits.

Eligible Expenses – Charges covered under a health plan.

Eligible Insured – Eligible covered individual pursuant to the insurance policy or certificate of coverage offered by payor.

Eligible Person – Person who meets the qualifications of a health plan contract.

Eligibility – Determined by requirements or conditions an employee must satisfy to participate in a plan, or conditions that an employee must satisfy to obtain a benefit. There usually is a period of time when potential members of a plan can enroll without evidence of insurability. The eligibility date is the date an individual and/or dependents become eligible for benefits under a plan.

Emergency center – A health care facility, for which the primary purpose is the provision of immediate, short-term medical care for urgent medical conditions.

Employee Assistance Plan (EAP) – A department designated to assist employees, their family members, and employers in finding solutions for workplace and personal problems. Services may include assistance for family/marital concerns, legal or financial problems, elder care, child care, substance abuse, emotional issues, and other daily living concerns. EAPs may address violence in the workplace, sexual harassment, dealing with troubled employees, transition in the workplace, and other events that increase the rate of absenteeism or employee turnover or lower productivity.

Employee Contribution – The portion of the insurance premium paid by the employee.

Employee Retirement Income Security Act of 1974 (ERISA) – A law that mandates reporting and disclosure requirements for group life and health plans.

Encounter – A member visit to the medical group with the intent of seeing a health care provider. There may be a variety of services performed at an encounter, i.e. a brief office visit, EKG, lab test, and an immunization.

Enrollee – A person eligible to receive, or receiving, benefits from an HMO or insurance policy. Includes both those who have enrolled or "subscribed" and their eligible dependents.

Enrollment – The number of members in an HMO. The number of members assigned to a physician or medical group providing care under contract with an HMO. Also, the process by which a health plan signs up individuals or groups as subscribers.

Enrollment Area – The geographic area within a designated radius (varies by HMO) of the PMG (Primary Medical Group) selected by the subscriber.

EOB (Explanation of Benefits) – A document typically provided to an insured and a provider after services are rendered. The document is generally sent by the claim-paying party and provides a summary of how a claim was paid based on the benefit plan.

Episode of care – All treatment rendered in a specified time frame for a specific disease.

EPO (Exclusive Provider Organization) – The EPO is a form of PPO in which patients must visit a caregiver that is on its panel of providers. If a visit to an outside provider is made, the EPO will offer limited or no coverage for the office or hospital visit.

ERISA The Employment Retirement Income Security Act of 1974 (ERISA) is the first federal legislation protecting the rights of America's workers who earn pension benefits. ERISA establishes and imposes a vast array of technical and complex rules that govern the organization and operation of employee retirement and welfare benefit plans. To protect the rights of plan participants, ERISA requires plan administrators to abide by the act's reporting, disclosure and fiduciary standards.

Events – A term which refers to any medical service a patient receives and can include, but is not limited to hospitalizations, out patient procedures of diagnostic tests, physical therapy, etc.

Exclusions – Specific services or conditions which are not covered, or are limited under the insured's Benefit Plan Design.

Experimental Procedures – Also called investigational or unproved procedures, this covers all health care services, supplies, treatments, or drug therapies that have been determined by the health plan to not be generally accepted by health care professionals as effective in treating the illness for which their use is proposed.

Extended Care Facility – A nursing home-type setting that offers skilled, intermediate, or custodial care.

Extension of Benefits – Some plans provide for extension of benefits for a set period of time to disabled persons beyond the termination of coverage under the plan. Benefits are provided only for the disabling condition and require continuous disability.

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Federal Employees Health Benefits Program (FEHBP) – The health benefits program for federal employees that is administered through the U.S. Office of Personnel Management.

Final Enrollment – A complete listing of employees covered on the effective date of coverage. They must be eligible by the definition established in the plan document.

Flexible Benefits Plan – A type of benefits program that offers employees a menu of benefit options, allowing them to create a benefits package which best suits their individual needs.

Formulary – The panel of drugs chosen by a hospital, MCO, or other health plan that is used to treat patients. Drugs outside of the formulary are only used in rare, specific circumstances.

Freestanding Emergency Medical Service Center – A health care facility that is physically and financially separate from a hospital, the primary purpose of which is to provide immediate, short-term medical care for urgent medical conditions. Also called an emergicenter.

Fungible Unit – In this case, a unit of hospital capacity that can be satisfactorily replaced by another unit. Two semiprivate rooms on the same floor of the same hospital, for instance, would ordinarily be fungible with each other, but not with a private room, even on the same floor.

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Gatekeeper Model – A primary care case management model used by health plans. The gatekeeper requires all care, except for true emergencies, be authorized by a member's primary care physician before care is rendered.

Generic Drug – A chemically equivalent copy designed from a brand-name drug whose patent has expired. Typically less expensive and sold under the common name for the drug, not the brand name.

Group Health (aka Accident & Health (A&H)) – Term utilized to reference a plan that provides for medical benefits, usually through ones employer.

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Health Risk Assessment – A set of questions designed to identify personal health risks and suggest lifestyle modifications to reduce risks.

Home Care – In contrast with inpatient and ambulatory care, home care is medical care ordinarily administered in a hospital or on an outpatient basis; however, the patient is not sufficiently ambulatory to make frequent office or hospital visits. In these patients, intravenous therapy, for example, is administered at the patient's residence, usually by a health care professional. Home care reduces the need for hospitalization and its associated costs.

Hospice – A health care facility that provides supportive care for the terminally ill.

Hospital Day – A term to describe any twenty-four hour period commencing at 12:00 a.m., or 12:00 p.m., whichever is used by a hospital to determine a hospital day, during which a patient receives hospital services at the hospital.

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ID Card – Identification cards are provided to all insureds for proper identification under their group health plan. ID card information helps providers verify patient eligibility for coverage.

Incentives – A mechanism utilized to motivate insureds to achieve the desired result. For example, a benefit plan may provide 100% coverage if a PPO provider is used. The same benefit plan may only provide 70% coverage if a non-PPO provider is used. Paying 100% when a PPO provider is used, encourages the insured to use PPO providers. If they do not, they will bear the responsibility of 30% of the bill.

Incidence – In epidemiology, the number of cases of disease, infection, or some other event having their onset during a prescribed period of time in relation to the unit of population in which they occur. Incidence measures morbidity or other events as they happen over a period of time.

Indemnity Plan – A type of health benefits plan under which the covered person pays 100% of all covered charges up to an annual deductible. The health benefits plan then pays a percentage of covered charges up to an out-of-pocket maximum. The covered person is able to utilize any provider of choice with no penalty.

Independent Medical Evaluation – An examination carried out by an impartial health care provider, generally board certified, for the purpose of resolving a dispute related to the nature and extent of an illness or injury.

Inpatient – A patient admitted to a hospital, who is receiving services under the direction of a physician for at least 24 hours.

Integrated Health Care System – Health care financing and delivery organizations created to provide a "continuum of care," ensuring that patients get the right care at the right time from the right provider. This continuum of care from primary care provider to specialist and ancillary provider under one corporate roof guarantees that patients get cared for appropriately, thus saving money and increasing quality of care.

Intermediate Care Facility – A facility providing a level of care that is less than the degree of care and treatment that a hospital or skilled nursing facility (SNF) is designed to provide, but greater than the level of room and board.

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JCAHO Joint Commission on the Accreditation of Healthcare Organizations – This is the peer review organization which provides the primary review of hospitals and healthcare providers. Many insurance companies require providers to have this accreditation in order to seek 3rd party payment, although, many small hospitals cannot afford the cost of accreditation.

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Legend Drug – A drug that, by law, can be obtained only by prescription and bears the label, "Caution: Federal law prohibits dispensing without a prescription."

Lifetime Maximum – 1) Maximum benefits payable under the employer's plan, per person. 2) Maximum payable under the Specific Stop Loss contract per person.

Long-Term Care – Services ordinarily provided in a skilled nursing, intermediate care, personal care, supervisory care, or elder care facility.

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Maintenance Medication – Medications that are prescribed for long-term treatment of chronic conditions, such as diabetes, high blood pressure or asthma.

Managed Care – A general term for the activity of organizing doctors, hospitals, and other providers into groups to improve the quality and cost-effectiveness of health care.

Managed Care Organization (MCO) – A managed care organization may be a physician group, health plan, hospital or health system (i.e. any organization that is accountable for the health of an enrolled group of people). MCOs include HMO, PPO, POS, EPO, PHO, IDS, AHP, IPA, etc. Usually when one speaks of a managed care organization, one is speaking of the entity which manages risk, contracts with providers, is paid by employers or patient groups, or handles claims processing.

Managed Care Plan – A health plan that uses managed care arrangements and has a defined system of selected providers that contract with the plan. Enrollees have a financial incentive to use participating providers that agree to furnish a broad range of services to them. Providers may be paid on a pre-negotiated basis.

Managed Health Care – Administrative firms that manage the allocation of health care benefits.

Mandated Benefits – Health benefits that health care plans are required by state or federal law to provide to members.

Medicaid (Title XIX) – Government entitlement program for the poor who are blind, aged, disabled or members of families with dependent children (AFDC). Each state has its own standards for qualification. A federally aided, state-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care. All states but Arizona have Medicaid programs.

Medical Management Services – System for reviewing the appropriate and efficient allocation of hospital resources and/or medical services given or proposed to be given to an eligible covered individual.

Medical Protocols – Medical protocols are the guidelines that physicians in the future may be required to follow in order to have an acceptable clinical outcome. The protocol would provide the caregiver with specific treatment options or steps when faced with a particular set of clinical symptoms, signs, or laboratory data. Medical protocols would be designed through an accumulated database of clinical outcomes.

Medically Necessary – Medical Necessity – Services or supplies which meet the following tests: They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; They are provided for the diagnosis or direct care and treatment of the medical condition; They meet the standards of good medical practice within the medical community in the service area; They are not primarily for the convenience of the plan member or a plan provider, and, They are the most appropriate level or supply of service which can safely be provided.

Medicare - An entitlement program run by the Health Care Financing Administration of the federal government through which people aged 65 years or older receive health care insurance. Part A covers hospitalization and is compulsory benefit. Part B covers outpatient services and is a voluntary service.

Medigap – Insurance provided by carriers to supplement the monies reimbursed by Medicare for medical services.

Member – A person eligible to receive benefits from an HMO or insurance policy. This includes both those who have enrolled or "subscribed" and their eligible dependents.

Multiple Option Plan – Employees are offered choice of several types of coverage, usually from among an HMO, PPO or a major medical indemnity plan.

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National Practitioner Data Bank – A computerized national data bank maintained by the federal government that contains information on physicians against whom malpractice claims have been paid or certain disciplinary actions have been taken.

Network – An affiliation of providers through formal and informal contracts and agreements. Networks may contract externally to obtain administrative and financial services. A "closed" network is one in which beneficiaries are not allowed to access non-network providers whereas an "open" network allows access to other providers at some cost to the beneficiary.

Non-participating Provider – (Also known as non-panel.) A health care provider who has not contracted with the carrier or health plan to be a participating provider of health care.

Nurse Practitioner – A registered nurse who has advanced skills in the assessment of physical and psychosocial health status of individuals, families, and groups in a variety of settings through medical history taking and physical examination.

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On-Line Adjudication – An electronic assessment of claims at the point of service meant to detect potential problems that should be addressed before drugs are dispensed to patients.

Open Access – Open access arrangements allow members to see participating providers, usually specialists, without referral from the health plan's gatekeeper.

Open Enrollment – A period during which an MCO allows persons not previously enrolled to apply for plan membership.

Outcome – Can refer to the following: the "outcome" or finding of a given diagnostic procedure; the results for a patient after care (i.e. how long it took to restore the patient's ability to walk or to work).

Outlier – A patient whose length of stay or treatment cost differs substantially from the stays or costs of most other patients in a diagnosis related group. Under DRG reimbursement, outliers are given exceptional treatment (subject to peer review and organization review).

Outlier Thresholds – The day and cost cutoff points that separate expected length-of-stay patients from patients requiring stays beyond the expected length-of-stay at the 95th percentile.

Out-of-Area – Refers to the treatment given a member outside the geographical limits of his own network. The coverage generally is restricted to emergency services.

Out-of-Network – When a patient goes to a provider not contracted by the managed care plan the patient is "out-of-network".

Out of Network Benefits – With most HMOs, a patient cannot have any services reimbursed if provided by a hospital or doctor who is not in the network. With PPOs and other managed care organizations, there may exist a provision for reimbursement of "out of network" providers. Usually this will involve a higher copay or a lower reimbursement.

Out-of-Plan – Those benefits that a plan supplies to its members outside the PPO or HMO network.

Outpatient Care – Care given a person who is not bedridden. Also called ambulatory care. Many surgeries and treatments are now provided on an outpatient basis, while previously they had been considered reason for inpatient hospitalization. Some say this is the fastest growing segment of healthcare.

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Partial Hospital Services – A mental health or substance abuse program operated by a hospital which provides clinical services as an alternative or follow-up to inpatient care.

Participant – An eligible covered individual pursuant to the insurance policy or certificate of coverage offered by the client.

Participating Physician or Participating Provider – Refers to a provider under a contract with a health plan. A physician or hospital that has agreed to provide services for a set payment provided by a payer, or who agrees to other arrangements, or who agrees to provide services to a set of covered lives or defined patients.

Patient – The person under medical treatment.

PCP – Primary Care Physician who often acts as the primary gatekeeper in health plans. In HMOs all members must choose or are assigned a PCP and the PCP must approve referrals to specialists.

Physical Therapy – Rehabilitation concerned with restoration of function and prevention of physical disability following disease, injury or loss of body part.

Physician Assistant (P.A.) – A health care professional certified to perform certain duties such as history taking, diagnosis, drawing blood samples, urinalysis and injections under the supervision of a physician.

Physician Dispensing – A physician gives the patient his or her initial doses of a commonly prescribed drug during the office visit. The prescription is usually refilled at the pharmacy, and not the physician's office. Doctors who dispense medications usually stock 20 to 30 drugs (antibiotics, anti-inflammatories, etc.).

Point-of-Service Plan (POS) – Managed care plan which specifies that those patients who go outside of the plan for services may pay more out of pocket expenses. A health insurance benefits program in which subscribers can select between different delivery systems (i.e., HMO, PPO and fee-for-service) when in need of health care services and at the time of accessing the services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from the "in network" or approved providers are less than when care is rendered by non-contracting providers. This is a method of influencing patients to use certain providers without restricting their freedom of choice too severely.

Policyholder – The group or individual to whom an insurance contract is issued.

Practice Parameters – The American Medical Association defines practice parameters as strategies for patient management, developed to assist physicians in clinical decision making. Practice parameters may also be referred to as practice options, practice guidelines, practice policies, or practice standards.

Practice Guidelines – Practice guidelines are systematically developed statements on medical practices that assist a practitioner in making decisions about appropriate health care for specific medical conditions. Managed care organizations frequently use these guidelines to evaluate appropriateness and medical necessity of care. Practice guidelines are developed with the "long view" of health in mind. This is fundamental to managed care organizations that want to keep the customers they have. Physicians in managed care environments, therefore, are motivated to provide high quality medicine.

Pre-Admission Review, Pre-Admission Certification, Pre-Certification, or Pre-Authorization – Review of "need" for inpatient care or other care before admission. This refers to a decision made by the payer, MCO or insurance company prior to admission. The payer determines whether or not the payer will pay for the service. Most managed care plans require pre-cert. This is a method of controlling and monitoring utilization by evaluating the need for service prior to the service being rendered. The practice of reviewing claims for inpatient admission prior to the patient entering the hospital in order to assure that the admission is medically necessary.

Pre-existing Condition – Any medical condition that has been diagnosed or treated within a specified period before the member's effective date of coverage under the group contract.

Preferred Provider – Physicians, hospitals and other healthcare providers who contract to provide health services to insureds covered by a particular health plan.

Preferred Provider Health Care Act of 1985 – A federal law easing restrictions on PPOs and allowing subscribers to use health care providers outside of the PPO.

Preferred Provider Organization (PPO) – PPOs are managed care organizations that offer integrated delivery systems (i.e., networks of providers) that are available through a vast array of health plans and are readily accountable to purchasers for cost, quality, access, and services associated with their networks. They use provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long-term cost savings.

Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination, immunization, and well-person care.

Primary Care – Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians – who are often referred to as primary care practitioners or PCPs. Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in an ambulatory setting, with referral to secondary care specialists, as necessary.

Primary Care Physician – Referred to as a "gatekeeper" within an HMO or POS plan, the job of the primary care physician in a managed care organization is to promote the health of specified members. This physician is responsible for orchestrating the medical care process, by referring a patient on for specialized diagnosis and treatment, or by caring for that patient then and there. Primary care physicians often participate in teams made up of specialists and other health professionals to study and improve how care is provided, particularly for patients at highest medical risk.

Principal Diagnosis – The medical condition that is ultimately determined to have caused a patient's admission to the hospital. The principal diagnosis is used to assign every patient to a diagnosis-related group. This diagnosis may differ from the admitting and major diagnoses.

Privileges – The authority granted, usually by a hospital or surgical center, allowing a provider of health care services to perform services at that hospital or surgical center. There are varying levels/classifications of privileges: courtesy, provisional, consulting, admitting, etc.

Provider – Facility or practitioner who, for a fee, dispenses healthcare services or supplies to the public.

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Quality – Defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer.

Quality Assurance (QA) – Activities and programs intended to assure the quality of care in a defined medical setting. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing its effectiveness and may measure care against pre-established standards.

Quality Improvement (QI) – The more commonly used term in healthcare, replacing Quality Assurance. QI implies that concurrent systems are used to continuously improve quality, rather than reacting when certain baseline statistical thresholds are crossed. Quality improvement programs usually use tools such as cross-functional teams, task forces, statistical studies, flow charts, process charts, etc.

Quality-of-Life Measures – An assessment of the patient's perceptions of how they deal with their disease or every day life when suffering from a particular condition. It is subjective in the sense that the information cannot be measured objectively; however, it has been in the health care literature for at least 25 years. It has been tapped in the area of pharmaceuticals most recently in the last seven or eight years. Through statistical means, the indices that

have been developed to measure various quality-of-life aspects have been validated over time, and these measures are reliable and reproducible.

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Referral – The process of sending a patient from one practitioner to another for healthcare services. Health plans may require that designated primary care providers authorize a referral for coverage of specialty services.

Referral Center (also called Triage, Call Center, 24-Hour Certification) – This is a mechanism established by health plans to direct patients to approved hospitals and doctors. Often the referral center serves a UR function and pre-certifies the care. These centers are also used by hospitals to refer patients to certain doctors, reduce use of the emergency room or to provide follow-up patient contact. Managed care organizations utilize these centers as their central hub of communications with patients and providers at the time of service.

Retrospective Review Process – System for analyzing medical necessity and appropriateness of services rendered. A review that is conducted after services are provided to a patient. The review focuses on determining the appropriateness, necessity, quality, and reasonableness of health care services provided.

Rural Health Clinic – A public or private hospital, clinic or physician practice designated by the federal government as in compliance with the Rural Health Clinics Act. The practice must be located in a medically underserved area or a health professions shortage area and use a physician assistant and/or nurse practitioners to deliver services.

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Schedule of Benefits – An outline of the benefits described in the plan document. Often supplies the exact values of items referred to in the body of the plan document such as the deductible.

Screening – The method by which MCOs limit access to unnecessary health care. In most HMOs, a phone call to the physician is required before an office visit can be arranged. Gatekeepers and concurrent review are other methods of screening patients.

Secondary Insurance – Term utilized when referring to the presence of insurance coverage through two different sources at the same time. For example, a husband and wife may each have insurance coverage through their respective employers.

Self-Funding – Employer or organization assume complete responsibility for health care losses of its covered employees. This usually includes setting up a fund against which claim payments are drawn and claims processing is often handled through an administrative services contract with an independent organization. In this case, the employer does not pay premiums to an insurance carrier, but rather pays administrative costs to the insurance company or health plan, treating them as a third party administrator (TPA) only.

Self-Insurance/Self-Insured – Term used to reference an organization that provides its own insurance to its employees without the use of an outside insurance company. In some cases, the organization financially funds the monies needed to pay employees' health insurance claims. Whereas, when there is no self-insurance, usually the employer would charge each employee a premium, and the premium is given to the insurance company, and the insurance company pays claims according to the benefit plan.

Sentinel Event – An adverse health event that could have been avoided through appropriate and medically necessary care.

Skilled Nursing Facility (SNF) – Typically an institution for convalescence or a nursing home, the skilled nursing facility provides a high level of specialized care for long-term or acute illness. It is an alternative to extended hospital stays or difficult home care.

Specialists – Providers whose practices are limited to treating a specific disease (e.g. oncologists), specific parts of the body (e.g., ear, nose and throat), a specific age group (e.g. pediatrics), or specific procedures (e.g. oral surgery).

Standard Benefit Package – A set of specific health benefits offered by delivery systems.

Status Change – A lifestyle event that may cause a person to modify their health benefits coverage category. Examples include, but are not limited to, the birth of a child, divorce marriage.

Subscriber – Person responsible for payment of premiums, or person whose employment is the basis for membership in a health plan.

Summary Plan Description – A description of the entire benefits package available to an employee as required to be given to persons covered by self-funded plans.

Superbill – A government issued billing form used by health care providers.

Surgicenter – A separate, freestanding medical facility specializing in outpatient or same-day surgical procedures. Surgicenters drastically reduce the costs associated with hospitalizations for routine surgical procedures because extended inpatient care is not required for specific disorders.

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Tele-Medicine – The provision of consultant services by off-site physicians to health care professionals on the scene as by means of closed-circuit television; the ability of healthcare providers to examine patients remotely by means of a computer.

Tertiary Care – Tertiary care is administered at a highly specialized medical center. It is associated with the utilization of high-cost technology resources.

Therapeutic Substitution – A drug that is believed to be therapeutically equivalent (i.e., will achieve the same outcome) to the exact drug prescribed by a physician. The drug is substituted by the dispensing pharmacist without the need to obtain permission from the physician. Therapeutic substitution is generally mandated by formulary or cost-containment concerns.

Third Party Administrator (TPA) – An organization that is outside of the insuring organization that handles the administrative duties and sometimes utilization review. Third-party administrators are used by organizations that actually fund the health benefits but do not find it cost effective to administrate the plan themselves.

Treatment Episode – The period of treatment between admission and discharge from a modality, e.g., inpatient, residential, partial hospitalization, and outpatient. Many healthcare statistics and profiles use this unit as a base for comparisons.

Triage – The evaluation of patient conditions for urgency and seriousness, and establishment of a priority list for multiple patients.

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Urgent Care Center – A medical facility where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate, non-emergency care.

Utilization Management – The act of overseeing the usage of benefits and services provided to an insured. The purpose is to reduce unnecessary services through many mechanisms such as pre-certification, retrospective review, case management, etc.

Utilization Review (UR) – Performed by the health plan to discover if a particular physician-provider is spending as much of the health plan's money on treatment or any specific portion thereof (e.g., specialty referral, drug prescribing, hospitalization, radiologic or laboratory services) as his or her peers. This study will help determine if a physician will obtain any of the money in the withhold fund at the end of the health plan's fiscal year.

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Validation Criterion – Determination of whether a patient had the diagnosis or problem ascribed to him or her in the patient medical record.

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Wellness – A dynamic state of physical, mental and social well-being. A way of life which equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses. A lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle. Preventive medicine associated with lifestyle and preventive care that can reduce health care utilization and costs.

Work-Related Injury/Illness – A term used to identify incidents that occur while at work, for which worker's compensation insurance may be responsible.

Workers' Compensation – A state-governed system that addresses work-related injuries. Employers assume the cost of medical treatment and wage losses stemming from a workers' job-related injury. In return, employees give up the right to sue employers.

Work-up – The total patient evaluation, which may include assessments, radiologic series, medical history, and diagnostic procedures.