

SECTION 11

Glossary of Terms

ALOS (Average Length Stay)	The average length of stay is calculated by dividing the total patient days incurred by the number of admissions or discharges during a specific period.
AMBULATORY PATIENT CARE	Health services provided without hospitalization (Out Patient Surgery) May be conducted in a doctor's office, clinic, medical center or a hospital outpatient facility.
AMOUNT ALLOWED	The adjusted dollar amount of charges presented by the participating provider based upon a fee schedule set forth by MercyCare Insurance Company (MCIC).
AMOUNT BILLED	The amount for service(s) as submitted on a claim form (HCFA 1500) by a participating provider.
AUTHORIZATION	Written consent by the MCIC Quality Health Management Team and/or MCIC Medical Director to provide payment for services for a Plan Member.
BENEFIT PACKAGES	A term to describe various written sets of benefits which are sold by Insurance Companies and Managed Care Plans to individuals, employer groups, associations, etc.
CAPITATION	Amount pre-paid to providers monthly for each patient in a medical group. The provider has a specific set of services which are included in the capitation payment.
CERTIFICATE	Certificate means this Certificate of Coverage which has been issued to you and which summarizes the terms, conditions, and limitations of your health coverage.
CLAIM FORM	A HCFA 1500 completed by the MCIC Provider's office staff or contracting facility after a Member has received care. This form serves as a billing document, as well as a medical record. It is important that these forms be completed in their entirety with accurate CPT and ICD 9 codes, as reimbursement for services rendered is based upon the information submitted.
COB (Coordination of Benefits)	Pertains to the coordination of two (2) or more health plans, when a Member has other coverage. MCIC may coordinate with other plans, reducing the MCIC claims expenses. (COB is further explained in Section 3 of this manual.)

COINSURANCE	Coinsurance means a charge, expressed as a percentage of the fee for covered services, that members are required to pay for certain covered services provided under their policy. Members are responsible for payment of any coinsurance charge directly to the network or participating or non-participating provider when covered services are received.
CONTRACTED AMOUNT	The amount the provider agrees to accept as payment in full for covered services rendered.
COPAYMENT	Co-payment means a charge, expressed as a fixed dollar amount, the member is required to pay for certain covered services provided under the policy. Members are responsible for the payment of any co-payment directly to the participating or non-participating provider when covered services are received. Co-payments are not applicable toward the contract year out-of-pocket maximum.
CORRECTIVE APPLIANCES	Equipment designed to aid in functioning or to correct malfunctioning parts of the body. Please call MCIC for description of specific coverage.
COSMETIC SURGERY	A procedure to revise or change the structure, configuration or relationship of any feature of the human body which would be considered within the range of "normal" and acceptable variation for age and ethnic origin and, in addition, is performed for a condition which is determined, by medical opinion, not to be medically necessary.
COVERAGE	Health care benefits as described in a benefit package sold by MCIC.
CPT (Current Procedural Terminology)	Descriptive terms and identifying codes for reporting medical services and procedures performed by health care providers. The purpose of this terminology is to provide uniform language that will accurately designate medical, surgical and diagnostic services and will, thereby, provide an effective means of reliable and consistent communication on claims forms.
CREDENTIALING	The gathering and review of specific provider information, including documents such as license, malpractice policy face sheet with expiration date shown, DEA Certificates, etc.
DEDUCTIBLE	Deductible means a pre-determined amount of money that an individual member may have to pay before benefits are payable by MercyCare. The single deductible applies to each member each contract year, and the family deductible amount is the most that the employee and his or her dependents must pay each contract year. Only charges for covered services may be used to satisfy the deductible. The amount of the deductible, if any, is stated in the Schedule of Benefits.

DEPENDENTS

Dependent means the following:

1. an employee's lawful spouse; and/or
2. an employee's unmarried and natural blood-related child, stepchild, legally adopted child or child placed in the custody of the employee for adoption (as provided for in section 632.896 of the Wisconsin Statutes) whose age is less than the limiting age stated in the schedule of benefits. Adopted children become dependents when placed in the custody of the parent; and/or
3. grandchildren if the parent is a dependent child. The dependent grandchild will be covered until the end of the month in which the dependent child turns age 19.

If the employee is the father of a child born outside of marriage, the child does not qualify as a dependent unless there is a court order declaring paternity or acknowledgement of paternity is filed with the Wisconsin Department of Health and Family Services or the equivalent agency if the birth was outside of the state of Wisconsin. Upon qualification, coverage for the child will be effective according to the Eligibility and Effective Date of Coverage section.

A spouse and stepchildren cease to be dependents at the end of the month in which a divorce decree is granted, and may be terminated subject to Continuation and Conversion privileges. Other children cease to be dependents at the end of the calendar year in which they reach the limiting age stated in the Schedule of Benefits or at the end of the month in which they marry, whichever occurs first, except that:

1. Children over the limiting age who are full-time students, if otherwise eligible, cease to be dependents at the end of the calendar year in which they cease to be full-time students or in which they turn the age specified in the Schedule of Benefits for full-time students, whichever occurs first.

Full-time student means the child is in regular full-time attendance at an accredited secondary school; accredited vocational, technical, or adult education school, or an accredited college or university which provides a schedule of courses or classes and whose principal activity is the provision of an education. Proof of attendance is required upon request from MercyCare. Full-time student status is to be defined by the institution in which the student is enrolled. Student status includes any intervening vacation period if the child continues to be a full-time student.

2. A covered dependent child who attains the limiting age while insured under the policy shall remain eligible for benefits if he or she is incapable of self-sustaining employment because of mental retardation or physical handicap which existed before the dependent attained the limiting age. The dependent must continue to be chiefly dependent on the employee for support and maintenance.

Written proof of incapacity and dependency must be provided to MercyCare in a form satisfactory to MercyCare within 31 days after the dependent's attainment of the limiting age. MercyCare, at its sole discretion, may require

the dependent to be examined from time to time by a network provider for the purpose of determining the existence of the incapacity prior

to granting continued coverage. Such examinations may occur at reasonable intervals during the first two years after continuation under this section is granted and annually thereafter. The employee must notify MercyCare immediately of a cessation of incapacity or dependency.

3. A child who is considered a dependent ceases to be a dependent on the date the child becomes insured as an eligible employee.

DETOXIFICATION A treatment which is medically necessary in the judgment of the physician or mental health professional to prevent possible life-threatening consequences or withdrawal from a habitually used substance. Becoming sober or "drying out" in the absence of serious medical consequences is not considered detoxification.

**DIAGNOSES
CODES (ICD-9)** Numeric codes used to identify diagnoses on claim forms.

DME
(Durable
Medical
Equipment) Equipment which meets the criteria of the following: able to withstand repeated use; is primarily and customarily used to serve a medical purpose; and is not generally useful except for the treatment of bodily injury or sickness.

DOS
(Date of
Service) The date on which a particular service is/was rendered.

ELIGIBILITY Qualified to obtain covered services.

**ELIGIBLE
DEPENDENTS** A dependent of a covered employee who meets the requirements specified in the group contract to qualify for coverage and for whom premium payment is made.

EMERGENCY Emergency means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson with an average knowledge of health and medicine reasonably to conclude that, without immediate attention, could likely result in death or serious injury to your body.

Examples of emergency care are, but are not limited to:

- Acute allergic reactions
- Acute asthmatic attacks
- Convulsions
- Epileptic seizures
- Acute hemorrhage
- Acute appendicitis

- Coma
- Heart attack
- Attempted suicide
- Suffocation
- Stroke
- Drug overdose
- Loss of consciousness
- Any conditions for which members are admitted to the hospital as an inpatient from the emergency room.

These and other acute conditions are emergencies when these four Elements exist:

- They require medical care for accidental injury or illness;
- Severe symptoms are sudden and unexpected. They must be severe enough to cause a person to seek medical help right away, no matter what time it is;
- Immediate care must be secured. If it is not, the condition will not be deemed an emergency ; and
- Diagnosis or the symptoms themselves show that immediate care was required.

ENCOUNTER A face-to-face meeting between a covered person and a health care provider where services are provided.

ENROLLEE An individual who is enrolled for coverage under a health plan contract and who is eligible on his/her own behalf (not by virtue of being an eligible dependent) to receive the health services provided under the contract.

ENROLLMENT FORM Enrollment form means the form completed by a potential member requesting coverage from MercyCare and listing all dependents to be covered on the effective date of coverage.

EOB
(Explanation of Benefits) The statement sent to covered persons by the Health Plan listing services provided, amount billed, and payments made.

EOMB
(Explanation of Medicare Benefits) The statement sent to covered persons by Medicare listing services provided, amount billed, and payments or denial made Medicare.

EOP
(Explanation of Payment) Written explanation by insurance company for payment or denial of payment sent to the provider billing for the services.

EXPERIMENTAL/ INVESTIGATIONAL Experimental or investigative means the use of any service, treatment, procedure, facility, equipment, drug, devices or supply for a member's bodily injury or sickness that:

- A. Requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or
- B. Is not yet recognized as acceptable medical practice to treat that bodily injury or sickness, as determined by MercyCare for a member's bodily injury or sickness.

The criteria that MercyCare's Quality Health Management Team uses for determining whether a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be experimental or investigative include whether:

- A. It is commonly performed or used on a widespread geographic basis.
- B. It is generally accepted to treat that bodily injury or sickness by the medical profession in the United States.
- C. Its failure rate or side effects are unacceptable.
- D. The member has exhausted more conventional methods of treating the bodily injury or sickness.
- E. It is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

EXTENDED CARE FACILITY

A nursing home or nursing center which is licensed to operate in accordance with applicable state or local laws to provide 24 hour nursing care. Such facility may offer skilled, intermediate or custodial care, or any combination of these levels of care.

FAMILY DEPENDENT

A person enrolled for coverage under a health plan contract who is: the enrollee's spouse; or an unmarried dependent child (including a stepchild or legally adopted child) of either the enrollee or the enrollee's spouse, and whose principal place of residence is with the enrollee unless other arrangements have been made with the health plan. The definition also may be subject to certain conditions and limitations spelled out in the contract.

FEE SCHEDULE

A listing of codes and related services with pre-established payment amounts which could be percentages of billed charges, flat rates or maximum allowable amounts.

FULL-TIME STUDENT

A dependent claiming status as a full-time student must be enrolled in and attending full-time an accredited institution, such as a public or private secondary school, college, university or licensed trade school.

GROUP CONTRACT

The application and addenda, signed by both the Health Plan and the enrolling unit, which constitutes the agreement regarding the benefits, exclusions and other conditions between the Health Plan and the enrolling unit. Also, the agreement with persons who obtain coverage for themselves or for themselves and their children, whether under a group or individual program.

HCFA 1500 (Health Care Financing Admin.)	A universal form, developed by the government agency known as Health Care Financing Administration (HCFA), for providers of services to bill professional fees to health carriers.
HEALTH MAINTENANCE ORGANIZATION (HMO)	An entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed prepaid premium. There are four basic models of HMOs: group model, individual practice association, network model and staff model. Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO: <ol style="list-style-type: none"> 1. An organized system for providing health care or otherwise assuring health care delivery in a geographic area, 2. An agreed upon set of basic and supplemental health maintenance and treatment services, and 3. A voluntarily enrolled group of people.
HOSPITAL	Hospital means an institution that: <ol style="list-style-type: none"> A. Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to hospitals; B. Maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, bodily injury or sickness; C. Provides such care on an inpatient basis; and D. Provides continuous 24-hour nursing services by registered graduate nurses; <p>Or</p> <ol style="list-style-type: none"> A. Qualifies as a psychiatric or tuberculosis hospital; B. Is a Medicare provider; and C. Is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations. <p>Hospital does not mean an institution that is chiefly:</p> <ol style="list-style-type: none"> A. A place for treatment of chemical dependency B. A nursing home; or C. A federal hospital
ICD-9-CM CODES	See Service Codes
IDENTIFICATION CARD	Means the card that MCIC issues to members that indicates entitlement to receive covered services from network providers.
IN-SERVICE/ ORIENTATION	Presentation of MCIC policies and procedures presented to providers offices at the time new providers and/or new staff join MCIC.
INDEMNITY	An insurance program in which the insured person is reimbursed for covered expenses.
INPATIENT	An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours.

LIFE-THREATENING	A condition requiring immediate care, such as heart attack, severe bleeding, stroke, poisoning, unconsciousness, etc. which if not treated immediately could reasonably be expected to result in loss of life.
MEDICALLY NECESSARY	<p>Medically necessary means a service, treatment, procedure, equipment, drug, device, or supply provided by a hospital, physician, or other provider of health care that is required to identify or treat a member's bodily injury or sickness and which is determined by MercyCare to be:</p> <ol style="list-style-type: none"> 1. Consistent with the symptom(s) or diagnosis and treatment of the member's bodily injury or sickness; 2. Appropriate under the standards of acceptable medical practice to treat that bodily injury or sickness; 3. Not solely for the convenience of the member, physician, hospital or other provider of health care; 4. The most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the member; and 5. The most economical manner of accomplishing the desired result.
MEMBER	Member means the employee and his/her dependents who have been enrolled and are entitled to benefits under the policy.
MEMBER NUMBER	The identification number MCIC issues to each covered member. The number appears on the membership card.
NETWORK PROVIDER	Network provider means any provider in the same provider network as your primary care physician. A member can visit any network provider without a referral.
OBSERVATION	Generally referred to as a 23 hour observation stay in a hospital.
OUT-OF-AREA	Coverage for treatment obtained by a covered person outside the network service area.
OUT-OF-PLAN PROVIDER	Any provider not listed in the MCIC Plan Provider Directory.
OUTPATIENT	A person who receives health care services without being admitted as an inpatient to a hospital.
PARTICIPATING PROVIDER	Participating provider refers to any provider of health care that has signed an agreement with MCIC and is not a provider within a member's chosen provider network.
PCP (Primary Care Physician)	<p>Primary care physician means a physician practicing family medicine' internal medicine, or pediatrics who has accepted primary responsibility for the MCIC member's health care.</p> <p>A member must name a primary care physician on their enrollment form or on a later physician change form.</p> <p>Each family member may have a different primary care physician. A member's primary care physician:</p>

- Provides entry into MercyCare's health care system.
- Evaluates a member's total health care needs.
- Provides personal medical care in one or more medical fields.
- Is in charge of coordinating other health services and referring the member to other providers of health care when appropriate.

PM/PM

(Per member Per month) The unit of measure related to each effective member for each month the member was effective. The calculation is: # of members/member months (MM).

POINT-OF SERVICE (POS)

A Health Plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. Point-of-service can be provided in several ways:

- An HMO may allow members to obtain limited services from non-participating providers:
- An HMO may provide non-participating benefits through a supplemental major medical policy:
- A PPO may be used to provide both participating and non-participating levels of coverage and access; or
- Various combinations of the above may be used.

PREFERRED NETWORK

A provider network is a group of providers contracted with MCIC to provide services for members within a specific geographic location. The primary care physician the member selects directly determines the provider network with which the member will be associated.

PRE-CERTIFICATION

Term MCIC uses to describe the **participating provider** responsibility to inform MCIC of any hospital admissions, surgical procedures and other proposed procedures prior to services being rendered.

PRIOR-AUTHORIZATION

Prior authorization means obtaining MercyCare's approval before a member receives a service or supply. Any prior authorization requirement will be stated in the member's certificate or in the schedule of benefits.

PROSTHETICS

Artificial devices that replace missing body parts. Prosthetics are intended to restore function and/or movement. Call the Quality Health Management Team for specific coverage information.

REFERRAL	Referral refers to the form prepared in writing by a network provider. If the MCIC network provider feels that a member requires specialty care beyond that available from MCIC network providers, he/she may complete a referral form. However, such referrals must be submitted to MCIC Quality Health Management Team for consideration before any recommended treatment or services are obtained. The Quality Health Management Team must determine whether the request for services should be approved. Such referrals are not valid without the Medical Service Department's approval.
REHABILITATIVE CARE	Restorative services designed to achieve measurable improvement toward a Member's maximum physical potential, as related to daily living activities.
REINSURANCE	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. Also called risk control insurance or stop-loss insurance.
RIDER	Additional benefits purchased from MCIC to cover services that are not part of a basic contract. These may include but are not limited to eyewear, dental coverage, hearing aids and prescription drug coverage.
SELF-REFERRAL	When a member accesses a specialist physician without the knowledge or written direction of their PCP and MCIC.
SERVICE AREA	Service area means the geographical area in which MercyCare is authorized to offer a health plan.
SERVICE CODES	Numeric Codes used to identify services provided.
SINGLE CONTRACTS	A type of contract for individuals with no dependents.
SPECIALTY CARE PHYSICIAN	A physician who has advanced education and training in a specific area of clinical of practice.
STOP LOSS (Reinsurance)	<p>Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance:</p> <ol style="list-style-type: none"> 1. Specific or individual - reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as \$25,000 or \$50,000. 2. Aggregate - reimbursement is given for claims which in total exceed a predetermined level, such as 125% of the amount expected in an average year.

SUBROGATION	A procedure under which an insurance company can recover from third parties the full or some proportionate part of benefits paid to an insured. For example, should a claimant who has received benefits under a state's statutory plan covering disability benefits enter into litigation or make claim against a third party, the insurance carrier has a right to place a lien against any benefit the third party action may provide.
SUBSCRIBER	The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in an HMO or other health plan.
SUBSTANCE ABUSE	The taking of alcohol or other drugs at dosages that place a person's social, economic, psychological and physical welfare in potential hazard, or endanger public health, morals, safety or welfare, or a combination thereof. Also called chemical dependency.
UB-92	A revised version of the UB-82, a federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice, which was implemented October 1, 1993.
URGENT CARE	Urgent Care is care for an accident or illness that you need sooner than a routine doctor's visit. Examples of urgent care situations are broken bones, sprains, no-severe bleeding, minor cuts and burns, and drug reactions.
WITHHOLD	The "at-risk" portion of a claim that is deducted and withheld by the Health Plan before payment is made to a participating physician as an incentive for appropriate utilization and quality of care. This amount - for example, 20% of the claim - remains within the Plan and is credited to the doctor's account. The withhold can be used in instances where the Plan needs additional funds to pay for claims. The withhold may be returned to the physician in varying levels which are determined based on analysis of his/her performance or productivity compared against his/her peers.