General Reimbursement Policy Definitions

These are standard terms used within the majority of our reimbursement policies. For specific policy-related definitions, please view the individual policy. Provider and/or state contract definitions supersede the definitions listed below.

- **Benefits**: services covered by a health benefit plan and which the member may be eligible for, specific to her/his enrolled health plan
- **Bundled service**: an individual service that is included in a more complex or comprehensive service and billed on the same date of service as the more comprehensive service
- **Code editing logic**: a review and evaluation tool for accuracy and adherence of medical claims to accepted national industry standards, state standards, plan benefits and authorization guidelines
- **Code set**: under HIPAA, code sets are any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes or medical procedure codes
- **Consistency guidelines**: system logic that identifies services that are inconsistent in nature, including:
    - Age-specific services provided to a member not in the appropriate age range
    - Surgical procedures performed on a member who previously has had the respective organ or only body part of that kind removed
- **Continuity of care**: continuance of care or services rendered by a provider for the purpose of continued treatment due to the complexity or advanced phase of the medical condition for members who are newly enrolled and/or who need to avoid a lapse in care for a medical condition requiring continued care; continuity of care can also be established for existing members who have conditions that require treatment by a provider not currently in, or recently terminated voluntarily from, the network
- **Covered services**: medically necessary health services, as determined by the plan and described in the applicable health benefit plan, for which a member is eligible for coverage
- **Encounter:** record of a medically related service (or visit) rendered by a provider to a beneficiary who is enrolled in a participating health plan during the date of service; it includes, but is not limited to, all services for which the health plan incurred any financial responsibility
- **Episode of care:** a single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition
- **Facility-based provider**: a hospital, nursing home, or other medical or health-related service facility that provides care for the sick, injured or disabled or other care that may be a covered service in a health benefit plan
- **Fee schedule**: the complete listing of health plan rate(s) for specific services that represents payment for each unit of service allowed based on applicable coded service identifier(s) for covered services
- **Global allowance**: reimbursement for certain services or surgical procedures that are considered to be directly related to a procedure's global allowance will be considered integral/inclusive to that service and not allowed separate reimbursement; reimbursement for surgical procedures includes the preoperative services, surgical operation and uncomplicated postoperative-care visits
- **Global period:** a global period is the number of days prior to and/or following a procedure during which other necessary related services furnished by a provider are included in the global reimbursement allowance for a procedure

- **Incidental procedure**: an incidental procedure is performed at the same time as a more complex primary procedure; the incidental procedure requires minimum additional resources and/or is clinically integral to the performance of the primary procedure; procedures that are considered incidental when billed with related primary procedures on the same date of service will be denied
- **Level of care**: the intensity of medically necessary medical care required to achieve the treatment objectives
- **Maximum allowance:** the maximum amount a plan will pay for a covered health care service
- **Medical necessity criteria**: medically necessary services are all services that a medical practitioner exercising prudent clinical judgment would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, or disease or its symptoms, and that are:
    - In accordance with generally accepted standards of medical practice
    - Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease
    - Not primarily for the convenience of the covered individual, physician or other health care provider
    - Not more costly than an alternative service or sequence of services and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease
- **Medical records:** reports, notes, photographs, X-rays, or other recorded data or information (whether maintained in written, electronic or another form) that is received or produced by a health care provider or any person employed by the provider to document an episode of care, or encounter of service; these items contain information relating to the medical history, examination, diagnosis or treatment of the member for an identified episode of care or encounter for specific dates of service
- **Modifier**: modifiers are two-digit codes appended to a CPT or HCPCS code when appropriate; a modifier can consist of numeric or alphanumeric characters; modifiers provide payers with the additional information needed to process a claim, and they allow providers to indicate that a service for which the basic code description has not changed in definition but was altered or affected by some special circumstance
- **Mutually exclusive procedures**: two or more procedures that cannot usually be successfully performed together on the same patient and/or differ in technique or approach but lead to the same outcome; an initial service and subsequent service of this nature are considered mutually exclusive, and only one of the procedures is considered a covered service when medically necessary
- **Prior authorization:** an approval process for requested medical services, either by a servicing health care provider or the patient, to determine if a service is covered for reimbursement; prior authorization is determined by eligibility, plan benefits and medical necessity of the service being requested
- **Recoupment of payments:** retraction of monies paid to providers by offsetting future payments
- **Recovery of payments:** request for the provider to return payment
- **Routine medical and surgical supplies**: supplies that are customarily used in small quantities, usually included in the provider's supplies and not designated for a specific patient