APPENDIX III: DEFINITIONS
of the Professional Provider Office Manual

This is an appendix of the *Professional Provider Office Manual*, and is for informational purposes only. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.BCBSLA.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.BCBSLA.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Definitions

Affiliated

Two companies are affiliated when one company owns less than a majority of the voting stock or interest of the other, when one company owns a portion of the voting stock or interest of the other, or when both are subsidiaries of a third corporation. A subsidiary is a company where more than 50% of the voting shares are owned by another corporation, called the parent company. A subsidiary is also an affiliate company. Two subsidiaries of the same parent company are affiliates of each other.

Allied Health Provider

A person or entity other than a hospital, doctor of medicine, or doctor of osteopathy who is licensed by the appropriate state agency, where required, and/or approved by Blue Cross to render covered services. For coverage purposes, Allied Health Provider includes dentists, psychologists, retail health clinics, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, physician assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, certified registered nurse anesthetists, licensed clinical social workers, and any other health professional as mandated by state law for specified services, if approved by Blue Cross to render covered services.

Allowable Charge/Professional Allowance

The lesser of the billed charge or the amount Blue Cross establishes or negotiates as the maximum amount allowed for all provider services covered under the terms of your agreement.

Authorization

A determination by Blue Cross regarding an admission, continued hospital stay, or other healthcare service or supply which, based on the information provided, satisfies the clinical review criteria requirement for medical necessity, appropriateness of the healthcare setting, or level of care and effectiveness. An authorization is not a guarantee of payment. Additionally, an authorization is not a determination about the member's choice of provider.

Benefit(s)

Medical services, treatment, procedures, equipment, drugs, devices, items or supplies provided under a benefit plan. Benefits are based on the allowable charge for covered services.

Blue Advantage

Our Medicare Advantage networks that have been in effect since January 1, 2016, statewide.

Billed Charges

The total charges made by a provider for all services and supplies provided to the member.

Blue Cross

Refers to Blue Cross and Blue Shield of Louisiana.

Clean Claim

A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special or additional treatment that prevents timely payment from being made on the claim.

Coinsurance

The sharing of eligible charges for covered services between Blue Cross and the member. The sharing is expressed as a percentage. Once the member has met any applicable deductible amount, the member's percentage will be applied to the allowable charges for covered services to determine the member's financial responsibility. Blue Cross' percentage will be applied to the allowable charges for covered services to determine the benefits provided.

Consumer Directed Health Care (CDHC)

A broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs, and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information, and financial incentives.

As an umbrella term, CDHC encompasses multiple models and services including Consumer Directed Health Plans, high deductible health plans, member healthcare accounts, debit cards, member support tools, provider cost and profile information, e-business services, and next generation networks.

Consumer Directed Health Plans (CDHP)

High deductible health plans (HDHPs) partnered with member personal savings accounts (PSAs), such as a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA), or a Flexible Spending Arrangement (FSA), thereby forming a CDHP. The type of account used in these arrangements has strong implications to the administration of the CDHP, as the IRS regulations governing these tax-favored PSAs vary significantly.

High deductible health plans vary in design (deductible thresholds, preventive coverage, and more), and are offered and administered by a health insurance company, such as a Blue Cross Plan.

Coordination of Benefits (COB)

Determining primary/secondary/tertiary liability between various healthcare benefit programs and paying benefits in accordance with established guidelines when members are eligible for benefits under more than one healthcare benefits program.

Copayment (Co-pay)

The amount of charges for covered services which a member must pay. The copayment may be collected directly from the member by a network provider each time a specified covered service is rendered.

Covered Services

Those medically necessary healthcare services and supplies for which benefits are specified under a member contract/certificate.

Current Procedural Terminology (CPT)

System of terminology and coding developed by the American Medical Association that is used for describing, coding and reporting medical services and procedures.

Deductible

A specific amount of covered services, usually expressed in dollars, that must be incurred by the member before Blue Cross is obligated to member to assume financial responsibility for all or part of the remaining covered services under a member agreement.

Electronic Funds Transfer (EFT)

Allows payment to be sent directly to iLinkBlue enrolled providers' checking or savings accounts. With EFT, providers can view their Weekly Provider Payment Registers in iLinkBlue and they will not receive a Payment Register by mail.

Eligible Charges

Eligible charges are defined as total charges billed on a claim less denied charges including but not limited to claims editing and medical policy.

Emergency

A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: a) placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Experimental/Investigational

The use of any treatment, procedure, facility, equipment, drug, device or supply not yet recognized by the National Association of Blue Cross and Blue Shield Plans as accepted practice for treatment of the condition. Note: Blue Cross makes no payment for experimental/investigational services.

Explanation of Benefits (EOB)

A notice sent to the member after a claim has been processed by Blue Cross that explains the action taken on that claim.

Federal Employee Program (FEP)

A healthcare benefits plan designed for personnel employed by the Federal Government.

Flexible Spending Arrangement (FSA)

Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. FSAs can also be provided to cover childcare and transit expenses, but those accounts must be established separately from medical FSAs.

Grandfathered Plan

A health plan that an individual was enrolled in prior to March 23, 2010, and is still enrolled. Grandfathered plans are exempt from most changes required by PPACA. New employees may be added to group plans that are grandfathered and new family members may be added to all grandfathered plans.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), otherwise known as HIPAA, was enacted as a broad congressional attempt at incremental healthcare reform. The "Administrative Simplification" section of that law requires the United States Department of Health and Human Services (DHHS) to develop standards and requirements for maintaining and transmitting health information.

Health Reimbursement Arrangement (HRA)

An employer-funded plan that reimburses employees for Qualified Medical Expenses (QMEs); an HRA is funded solely by the employer. Reimbursements for medical expenses, up to a maximum dollar amount for a coverage period, are not included in an employee's income. Unused funds can be rolled over annually but are owned by the employer and thus are not portable when the employee leaves the employer's company.

Health Savings Account (HSA)

A tax-exempt trust or custodial account established exclusively for the purpose of paying qualified healthcare expenses of the account beneficiary who, for the months of which contributions are made to an HSA, is covered under a high-deductible plan. An HSA is employee-owned but can be funded by the employer and/or the employee. Unused funds are owned by the employee and thus are portable when the employee leaves the employer's company.

High Deductible Health Plan (HDHP)

A descriptive term relating to a broad category of health plans that feature higher annual deductibles than other traditional health plans. Deductibles typically exceed $1,000 for individual coverage and $2,000 for family coverage. This term encompasses those CDHP plans that are HSA qualified.

HSA Qualified High Deductible Health Plan

An individual or family health plan with minimum annual deductible and maximum out-of pocket amounts indexed annually for inflation according to Internal Revenue Code (IRC) §223(c)(2) and IRC §223(g)(1).

HMO Louisiana Select Network

A subset of HMO Louisiana providers who have signed a separate agreement with PLAN to provide services to Members with HMO Louisiana Select Network Contracts/Certificates.

HMO Louisiana Select Network Provider

Any physician or group of physicians, or any facility, including but not limited to, a hospital, clinical laboratory, free-standing ambulatory surgery facility, skilled nursing services who has entered into a HMO Louisiana Select Network contractual agreement with HMO Louisiana to provide Covered Services to Members.

iLinkBlue

A secure Web portal available at no cost for healthcare providers, designed to help you quickly complete important functions such as claims entry, authorizations and billing information.

Identification Card

The card issued to the member identifying him/her as entitled to receive benefits under a member contract/certificate for services rendered by healthcare providers and for such providers to use in reporting to Blue Cross those services rendered to the member.

Identification Number

The number assigned to the member and all of his/her Blue Cross records. This number is a unique number selected at random, has a three-character prefix in the first three positions, and is noted on the identification card.

International Classification of Diseases, 10th Revision (ICD-10-CM)

A numerical classification descriptive of diseases, injuries and causes of death.

Medically Necessary/Medical Necessity

Healthcare services, treatments, procedures, equipment, drugs, devices, items or supplies that a provider, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a. In accordance with nationally accepted standards of medical practice;
b. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
c. Not primarily for the personal comfort or convenience of the patient, physician or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Member

A subscriber or an enrolled dependent.

National Drug Code (NDC)

A unique 10-digit, three-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The segments identify the labeler or vendor, product (within the scope of the labeler), and trade package (of this product).

National Provider Identifier (NPI)

A 10-digit number unique to each provider that is issued by the Centers of Medicare and Medicaid Services (CMS). The NPI is required for providers to submit transactions to federal and state agencies, as well as file claims with private health plans.

Network/Participating Providers

Any physician or group of physicians, or any facility, including but not limited to, a hospital, clinical laboratory, free-standing ambulatory surgery facility, skilled nursing facility, hospice, home health agency, or any other health care practitioner or provider of medical services who has entered into a contractual agreement with Blue Cross to provide covered services to members.

Noncovered Service

A service and/or supply (not a covered service) for which there is no provision for either partial or total Benefit/payment under the member contract/certificate.

Non-participating Provider

Provider that has chosen not to sign a network agreement with Blue Cross.

Non-network/No network Participating Provider

A provider/specialty type that Blue Cross does not offer network agreements to.

Notification

A message sent to confirm, validate, acknowledge, or provide information from one entity to another.

Out-of-Network Provider

A provider that has signed a network agreement with Blue Cross, but is not in the specific network tied to the member's benefit.

Participating Plan

A licensee participating in Blue Bank ownership and governance. Also means: A licensee in whose service area a national account has employee and/or retiree locations, but in which the national account headquarters is not located unless otherwise agreed in accordance with National Account Program policies and provisions.

Patient Protection and Affordable Care Act (PPACA)

PPACA is legislation (Public Law 111-148) signed by President Obama on March 23, 2010. It is commonly referred to as the health care reform law.

Personal Savings Account (PSA)

A broad term used to represent the member's portfolio of accounts: Health Savings Account (HSA), Health Reimbursement Arrangement (HRA), Flexible Savings Account (FSA). This is also referred to as Health Care Accounts (HCA).

Physician Advisory Committee (PAC)

A committee made up of participating physicians throughout the state that meets on a periodic basis with Blue Cross to discuss and make recommendations concerning policies and procedures affecting the Blue Cross and HMO Louisiana networks.

Plan

Blue Cross and Blue Shield of Louisiana also referred to as Blue Cross.

Plan Review

A determination by the Plan regarding a healthcare service for the purpose of applying benefit coverages and limitations and medical policies to determine medical necessity, if the service is cosmetic, investigational or experimental in nature or if the service is covered under the member's benefit plan.

Prefix

A three-digit prefix to the member identification number that identifies the Blue Cross Plan or the national account in which the member is enrolled. FEP members' ID numbers will start with "R."

Professional Allowance/Allowable Charge

The lesser of the submitted charge or the amount established by the Plan as the maximum amount allowed for physician services covered under the terms of the member contract/certificate.

Provider

A hospital, allied health facility, physician, or allied health professional, licensed where required, performing within the scope of license, and approved by Blue Cross. If a provider is not subject to state or federal licensure, we have the right to define all criteria under which a provider's services may be offered to our members in order for benefits to apply to a provider's claims. Claims submitted by providers who fail to meet these criteria will be denied.

Provider Payment Register

A claims summary identifying all claims paid or denied, along with payment, is provided to the provider by electronic means when set up with EFT or by mail when not set up with EFT.

Qualified Medical Expenses (QME) Substantiation

Refers to the process of determining that expenses submitted to a PSA administrator to be paid from HRAs or FSAs meet the requirements defined by Internal Revenue Service (IRS) regulations. Eligible medical expenses are defined as those expenses paid for care as described in Section 213(d) of the Internal Revenue Code. Additionally, the IRS has allowed some over the counter drugs to qualify as eligible medical expenses. For more detailed information, please refer to IRS Publication 502. (See www.irs.gov/pub/irs-pdf/p502.pdf.)

Subscriber/Member

An eligible person who has satisfied the specifications of the agreement schedule of eligibility and has enrolled for coverage.

Subscriber Contract/Certificate

A contract/certificate or health benefit plan which provides for payment in accordance with the provider agreement and which is issued or administered by or through Blue Cross, its subsidiaries and affiliates and includes any national and regional group accounts of Blue Cross and Blue Shield of Louisiana or any other Blue Cross Plan, Blue Shield Plan, or the Blue Cross and Blue Shield Association having a Benefit provision for which Blue Cross acts as the control plan, a participating plan or service plan in providing those benefits. It also includes any health plans or programs sponsored, provided, indemnified, or administered by other entities or persons who have made arrangements with Blue Cross, such as network access-only agreements, to access and utilize the provider in connection with their managed care health plans or programs. Such entities or persons

may avail themselves of the same access to service and related rights as Blue Cross, and such entities or persons shall be bound to the same payment responsibilities in regard to their members as Blue Cross is for their respective members under the provider agreement. The participating provider will provide these services and look only to each joined entity or person for the Professional Allowance/Allowable Charge in the manner it would look to Blue Cross. The member contract/certificate or health benefit plan entitles members/members to receive healthcare benefits as defined in and pursuant to a member contract/certificate or health benefit plan.

Unbundled

Filing claims with two or more reimbursement/medical codes to describe a procedure performed when a single, more comprehensive reimbursement/medical code exists that accurately describes the entire procedure.