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Access+ Provider Group

A medical group or IPA that participates in the Access+ HMO program. The features of the Access+ Program include Access+ *Satisfaction* and Access+ *Specialist*.

Access+ Satisfaction®

A feature of the Access+ HMO program that allows HMO members to provide feedback regarding services received from HMO network physicians and their office staff.

Access+ SpecialistSM

A feature of the Access+ HMO program that allows HMO members to self-refer, for an increased copayment, to a specialist within their IPA/medical group for Access+ *Specialist* services without a referral from their primary care physician.

Access+ *Specialist* Services

Services covered under the Access+ *Specialist* option of the Access+ HMO Program.

Activities of Daily Living

Mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

Acute Care

Care rendered in the course of treating an illness, injury or condition that is marked by a sudden onset or abrupt change of status requiring prompt attention. It may include hospitalization, but of limited duration and not expected to last indefinitely. Acute care is in contrast to chronic care. See *Chronic Care*.

Administrative Services Only (ASO)

ASO accounts are self-funded, where the local plan administers claims on behalf of the account but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect medical benefits, submission of medical records, Coordination of Benefits, or timely filing limitations.

Blue Shield of California receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.

Advance Directives

Documents signed by a member that explain the member's wishes concerning a given course of medical care should a situation arise where he/she is unable to make these wishes known. Advance directives must be documented in a prominent place in the medical record for all Blue Shield members 18 years and older.

Glossary

Affordable Care Act

The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Allowed Amount

The adjudicated claim cost for covered benefits at the contracted rate, including the member's copayment/co-insurance portion.

Alternate Care Services Provider

Home health care agencies, pharmacy home infusion suppliers, home infusion suppliers and home medical equipment suppliers.

Ambulatory Surgery Center (ASC)

Any ambulatory surgical center that is certified to participate in the Medicare program under Title XVII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4. It is also known as a "surgicenter."

Ancillary Services

Ancillary services are defined as independent clinical laboratory services, durable/home medical equipment and supply services and specialty pharmacy services.

Appeal, Member

A request for Blue Shield's or Blue Shield's Life's reconsideration of an initial determination (either verbal or written) which resulted in the following:

- Complete denial of service, benefit, or claim
- Reduction of benefits or claim payment
- Redirection of service or benefits
- Delay of prospective authorization for service or benefits
- Underwriting Investigation Unit (UIU) cancellation of coverage or enrollee underwriting denials

Appeal, Provider

A written statement from a provider disputing the decision to reduce, delay, or deny services or benefits, requesting the original decision is altered or overturned.

ASP

ASP refers to the Average Sales Price is a market based price that reflects the weighted average of all manufacturer sales prices that includes all manner of discounts. The ASP is issued by CMS quarterly based on the information submitted by the manufacturer and is a reference point to estimate acquisition costs.

AuthAccel

An online authorization request tool available via Blue Shield's Provider Connection website at www.blueshieldca.com/provider. In addition to options for faxing, calling, or requesting authorizations by U.S. mail, AuthAccel presents an option for providers to complete, submit, track status, and receive determinations for medical and pharmacy prior authorizations. Registered users may access the tool in the *Authorizations* section, after logging into Provider Connection.

When providers submit pharmacy authorization requests via AuthAccel, it is not necessary for them to complete a separate California Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211), as the same information is built into the tool.

Authorization

A process required for certain services (e.g., approval to receive care from a provider other than the member's primary care physician) in order to determine medical necessity. Services without an authorization that require an authorization will be denied.

AWP

AWP refers to the Average Wholesale Price of pharmaceuticals dispensed per NDC Code as set forth in a nationally recognized pricing source such as First Data Bank and its supplements or other such sources, as determined by Blue Shield.

Balanced Budget Act of 1997 (BBA)

Legislation signed into law by President Clinton in August 1997. This legislation enacts the most significant changes to the Medicare program since its inception 30 years ago.

Benefits

Covered health care services pursuant to the terms of the member's health services contract.

Benefit Period (Blue Shield Medicare Advantage Plan)

A way of measuring the use of services under Medicare Part A. A benefit period begins on the first day of a Medicare-covered inpatient hospital stay and ends when a member has been out of the hospital (or other facility that primarily provides skilled nursing or rehabilitative services) for 60 consecutive days, including the day of discharge.

Glossary

Biosimilar

A Federal Drug Administration (FDA) approved biological product that is highly similar in structure and function to an existing biologic. Biosimilars have been tested to demonstrate no clinically meaningful differences in safety and efficacy from the original product.

BlueCard Access[®]

A toll-free number – **(800) 810-BLUE** – for you and members to use to locate healthcare providers in another Blue Plan’s area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

BlueCard *Eligibility*[®]

A toll-free number – **(800) 676-BLUE** – for you to verify eligibility, benefits coverage, share of cost information, and prior authorizations on patients from out-of-state Blue plans.

BlueCard National Doctor and Hospital Finder

www.bcbs.com/healthtravel/finder.html

A website you can use to locate healthcare providers in another Blue Cross and/or Blue Shield plan’s area. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you as a provider is incorrect on the website, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091.

BlueCard PPO

A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield plan’s area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard PPO Basic

A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield plan’s service area the PPO basic level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO Basic provider.

When you see the “PPOB” in a suitcase logo on the front of the member’s Blue plan ID card, it means the member has selected a PPO plan product from a Blue Cross Blue Shield plan. Since Blue Shield of California does not have a BlueCard PPO Basic network, providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California.

BlueCard PPO Member

A Blue plan patient who carries an ID card with a suitcase symbol containing “PPO” in it. Only members with this identifier can access the benefits of the BlueCard PPO.

BlueCard PPO Network

The network comprising those physicians, hospitals and other healthcare providers PPO members may elect to use to obtain the highest level of PPO benefits.

BlueCard PPO Provider

A doctor, hospital or other healthcare entity enrolled in a network of designated PPO providers.

BlueCard Routing Logic

A streamlined IT solution that Blue Shield of California developed that integrates with a provider's clearinghouse and/or eligibility and benefits verification vendor's system to simplify and automate selecting the correct California Blue plan for processing BlueCard claims. The BlueCard routing logic is an alternative to using our Claims Routing Tool on the Blue Shield Provider Connection website.

BlueCard Traditional

A national program that offers members traveling or living outside of their Blue plan's service area the traditional, or indemnity, level of benefits when they obtain services from a physician or hospital outside of their Blue plan's service area. These members will carry an ID card featuring an "empty" suitcase logo.

Blue Shield Medicare Advantage Plans

Blue Shield's Medicare Advantage plans; Blue Shield 65 Plus (HMO), Blue Shield Plus Choice Plan (HMO), Blue Shield Trio Medicare (HMO), Blue Shield Inspire (HMO), Blue Shield Vital (HMO) and Blue Shield Medicare (PPO). The terms "Medicare Advantage" and "MA-PD" may be used interchangeably throughout this manual.

Blue Shield Medicare Advantage Plan Member

An individual who meets all of the applicable eligibility requirements for membership, has voluntarily elected to enroll in Blue Shield Medicare Advantage HMO or PPO plan, has paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield Medicare Advantage HMO or PPO plan has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Blue Shield Medicare Advantage HMO Plan Network

A group of physicians, hospitals, and other healthcare providers that contracts with Blue Shield to provide medical and facility-based care to Blue Shield Medicare Advantage HMO plan members. When the member selects a Primary Care Physician (PCP), he or she is also choosing the hospital and specialty network associated with his/her PCP. This is different than the Access + HMO network.

Blue Shield Global Core[®]

A program that allows Blue plan members traveling or living abroad to receive nearly cashless access to covered inpatient hospital care, as well as access to outpatient hospital care and professional services from healthcare providers worldwide. The program also allows members of international Blue Cross and/or Blue Shield Plans to access domestic (U.S.) Blue provider networks.

Glossary

Blue Web

Blue Cross and Blue Shield Association's website at blueweb.bcbs.com which contains useful information for providers.

California Children's Services (CCS)

California Children's Services (CCS), formally known as the Crippled Children's Services, was introduced by the California Legislature in 1927. This program was developed to provide medical treatment and rehabilitation to children who suffer from catastrophic medical conditions. CCS is funded through county, state, and federal tax dollars, as well as through some fees paid by the families receiving care. CCS is not a Medi-Cal or Medicare program.

Capitation

A prepaid monthly fee paid to the IPA/medical group for each Blue Shield member in exchange for the provision of comprehensive health care services.

Case Rate

The all-inclusive rate paid, in accordance with the hospital contract Exhibit C, for specified types of care that are paid regardless of the type or defined duration of services provided by the hospital. For specified care/diagnoses, Blue Shield pays the stated Case Rate in lieu of the Per Diem rate.

Centers for Medicare & Medicaid Services (CMS)

An agency within the U.S. Department of Health and Human Services which administers the Medicare Program and with whom Blue Shield has entered into a contract to provide healthcare and Medicare prescription drug coverage to Medicare beneficiaries.

Chronic Care

Care (different from acute care) furnished to treat an illness, injury, or condition, which does not require hospitalization (although confinement in a lesser facility might be appropriate), that may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by a recurrence requiring continuous or periodic care, as necessary. *See Acute care.*

COBRA

Consolidated Omnibus Budget Reconciliation Act. It provides for the continuation of group health benefits for certain employees and their dependents (applies to groups of 20 or more employees). A member may elect to continue coverage under COBRA if coverage would continue as a result of a "qualifying event". (A qualifying event may be termination of employment or reduction of hours, etc.)

Coinsurance

The percentage amount that a member is required to pay for covered services after meeting any applicable Deductible. Specific coinsurance information is provided in the members' *Summary of Benefits*.

Coinsurance (Blue Shield Medicare Advantage HMO and PPO Plans)

The percentage of the Blue Shield Medicare Advantage HMO and PPO plans contracted payment rate or Medicare payment rate that a member must pay for certain services.

Commercial Plans or Programs

All plans other than Medicare Advantage plans, including, but not limited to, Blue Shield Preferred Plans, Access+ HMO® group benefit plans, Access+ HMO Plan for Individuals and Families, HMO POS plans, BlueCard, and government-sponsored programs (i.e., Healthy Families and Major Risk Medical Insurance).

Consumer Directed Healthcare/Health Plans (CDHC/CDHP)

Consumer Directed Healthcare (CDHC) is 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 plans provide 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.

Contracted Provider

A credentialed health care professional or facility that has a contract with Blue Shield to provide services to members.

Contract Year (Blue Shield Medicare Advantage HMO and PPO Plans)

The contract year for Medicare beneficiaries begins on April 1st and continues for a 12-month period. Note: the contract year for Group MA-PD members could begin at varying times of the year (for example July 1st or October 1st) and continues for a 12-month period.

Coordination of Benefits (COB)

A term used to describe a process to determine carrier responsibility when a member is covered by two or more group health plans. One of the carriers is considered the primary carrier and its benefits are paid first. Any balance is then processed by the secondary carrier, up to the limit of its contractual liability.

Copayment

The fixed dollar amount that a member is required to pay for covered services after meeting any applicable deductible. Specific copayment information is provided in the members' *Evidence of Coverage* or *Summary of Benefits*.

Cosmetic Procedure

Any surgery, service, drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic within the broad range of normal, but which is considered unpleasing or unsightly.

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Covered Services

Those services provided to a member pursuant to the terms of a group or individual health services contract and noted in the member's *Evidence of Coverage*. Medically necessary health care services, which a member is entitled to receive pursuant to the *Health Services Contract* and *Evidence of Coverage* applicable to the member. Except as otherwise noted in the member's *Health Services Contract* and *Evidence of Coverage*, covered services must generally be referred to and authorized in conformity with Blue Shield's Utilization Management programs.

Credentialing

The process in which Blue Shield verifies the evidence of a physician's education, residency training, clinical capabilities, licenses, references, board certification, state and federal disciplinary sanctions and other components of the physician's professional abilities and history.

Custodial Care

Care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self-care and/or supervisory care by a physician); or care furnished to a member who is mentally or physically disabled, and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or when despite such treatment, there is no reasonably likelihood that the disability will be so reduced.

Delegation

The process by which Blue Shield allows the IPA/medical group to perform certain functions that are considered the responsibility of Blue Shield for the purpose of providing appropriate and timely care for Blue Shield members.

Dependent (Commercial Only)

A dependent is an individual who is enrolled and maintains coverage in the Plan, and who are defined as:

1. A subscriber's legally married spouse who is:
 - a. Not covered for benefits as a subscriber; and
 - b. Not legally separated from the subscriber; or,
2. A subscriber's domestic partner who is not covered for benefits as a subscriber; or,
3. A child of, adopted by, or in legal guardianship of the subscriber, spouse, or domestic partner. This category includes any stepchild or child placed for adoption or any other child for whom the subscriber, spouse, or domestic partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for benefits as a subscriber, is less than 26 years of age, has been enrolled and accepted by Blue Shield of California as a dependent, and has maintained membership in accordance with the contract.

Dependent (Commercial Only) *(cont'd.)*

Note: Children of dependent children (i.e., grandchildren of the subscriber, spouse, or domestic partner) are not dependents unless the subscriber, spouse, or domestic partner has adopted or is the legal guardian of the grandchild.

4. If coverage for a dependent child would be terminated because of the attainment of age 26, and the dependent child is disabled, benefits for such dependent will be continued upon the following conditions:
 - a. The child must be chiefly dependent upon the subscriber, spouse, or domestic partner for support and maintenance;
 - b. The subscriber, spouse, or domestic partner submits to Blue Shield a Physician's written certification of disability within 60 days from the date of the employer's or Blue Shield's request; and
 - c. Thereafter, certification of continuing disability and dependency from a physician is submitted to Blue Shield on the following schedule:
 - i. Within 24 months after the month when the dependent would otherwise have been terminated; and
 - ii. Annually thereafter on the same month when certification was made in accordance with item 4 (a) above. In no event will coverage be continued beyond the date when the dependent child becomes ineligible for coverage under this plan for any reason other than attained age.
5. AB 570 requires an individual health plan/policy that provides dependent coverage to make dependent coverage available to a parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the health care service plan's service area.
 - a. The bill redefines "dependent" under both the Health and Safety Code and the Insurance Code to include the "parent or stepparent" of an individual, subject to applicable terms of the health benefit plan.
 - b. Under Section 152(d) of Title 26 of the United States Code, the term "qualifying relative" means, with respect to any taxpayer for any taxable year, an individual:
 - i. who bears a relationship to the taxpayer described in the statute, including parent or stepparent,
 - ii. whose gross income for the calendar year in which such taxable year begins is less than the exemption amount (as defined in 26 USC Section 151(d), currently listed as \$2000),
 - iii. with respect to whom the taxpayer provides over one-half of the individual's support for the calendar year in which such taxable year begins, and
 - iv. who is not a qualifying child of such taxpayer or of any other taxpayer for any taxable year beginning in the calendar year in which such taxable year begins.

Glossary

Direct Contract

An executed agreement between Blue Shield and an individual or group of individual providers for the purpose of providing health care services to Blue Shield enrollees.

Domestic Partner (California Family Code)

An individual who is personally related to the Subscriber by a registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Downstream Entity

All participating providers or other entities contracted or subcontracted with the IPA/medical group, including but not limited to individual physicians, ancillary providers, subcontracted administrative services vendors, third party administrators or management companies, as defined by CMS and the Medicare Advantage regulations.

Durable Medical Equipment (DME)

Equipment designed for repeated use, which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are Durable Medical Equipment such as oxygen ostomy and medical supplies.

Durable Power of Attorney

See *Advance Directives*.

Electronic Claim Submission

Electronic claim submission is the paperless submission of claims generated by computer software that is transmitted electronically to Blue Shield. Claim files are submitted to Blue Shield in the ASC X12 835 5010 format.

Electronic Data Interchange (EDI)

A computer-to-computer exchange of information between businesses. Use of electronic data interchange is considered an industry best-practice to optimize administrative efficiency, lower cost and reduce overall revenue cycle time.

Electronic Funds Transfer (EFT)

EFT is the electronic transfer of claim payments into a designated bank account based on information submitted by the provider. The EFT process is set up to ensure privacy in addition to being quick and efficient.

Electronic Provider Access (EPA)

Electronic Provider Access (EPA) is an online tool giving providers the ability to access out-of-area member's Blue plan provider websites to request medical authorization and pre-service review. To access the EPA tool, log into Provider Connection at www.blueshieldca.com/provider and click on *Pre-Service Review for Out-of-Area Members* within *Authorizations* section. Choose the *Electronic Provider Access* option and you will be connected directly to the Blue plan within a secured routing mechanism to begin your request.

Electronic Remittance Advice (ERA)

ERA is an electronic version of an explanation of medical payment in HIPAA-compliant files. ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format.

Eligibility Report

A report of members determined by Blue Shield to be eligible for benefits and for whom Blue Shield providers are compensated.

Emergency Services

Services necessary to screen and stabilize members in cases where an enrollee reasonably believed he/she had an emergency medical or psychiatric condition given the enrollee's age, personality, education, background, and other similar factors.

Employer Group

The organization, firm, or other entity that has at least two employees and who contracts with Blue Shield to arrange health care services for its employees and their dependents.

Essential Community Providers

Healthcare providers that serve predominantly low-income, high-risk, special needs and medically underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.

Evidence of Coverage and Disclosure

A summary of the Plan's coverage and general provisions under the health services contract. The *Evidence of Coverage* includes a description of covered benefits, member cost-sharing, limitations, and exclusion.

Exclusions

An item or service that is not covered by Blue Shield as defined in the *Evidence of Coverage* and *Disclosure*.

Glossary

Exclusive Provider Organization (EPO)

An Exclusive Provider Organization (EPO) is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

Expedited Appeals

A member, a member representative, or a physician on behalf of the member may request an expedited appeal of a denied prior authorization request because a member is experiencing severe pain or a member's health or ability to function could be seriously harmed by waiting for a standard appeal decision. Blue Shield will make a decision on an expedited appeal as soon as possible to accommodate the patient's condition not to exceed 72 hours from receipt of the request.

A request for a 72-hour/fast appeal consideration of a prior authorization request denial in which the health plan determines a member's health or ability to function could be seriously harmed by waiting for a standard appeal decision. A member, member representative, or physician on behalf of the member may request an expedited appeal.

Expedited Initial Determination

When Blue Shield's routine decision making process might pose an imminent or serious threat to a member's health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function, Blue Shield will make a decision on prior authorization requests relating to admissions, continued stays, or other healthcare services, as soon as medically indicated but no longer than 72 hours.

Expedited Review or Decision

The Knox Keene Act requires and provides for an expedited review (initial determination) and appeal process. When a member believes that his/her health and ability to function could be seriously harmed by waiting 30 days for a standard appeal, he/she may request an expedited review (initial determination) or appeal. NCQA CMS requirements, standards, and Blue Shield require that this request be processed within 72 hours. This request may be filed by the member, his/her representative or his/her physician on behalf of the member.

Experimental/Investigational Treatments

- Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device, or device usage, or supplies that are not recognized, in accordance with generally accepted professional medical standards, as being safe and effective for use in the treatment of an illness, injury, or condition
- Any service that requires federal or state agency approval prior to its use, where such approval has not been granted at the time the service or supply was provided
- Services or supplies which themselves are not approved or recognized, in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients

Explanation of Benefits (EOB)

A written statement to members identifying which services rendered are covered and not covered under their health plan. Services that are not covered are the member's financial responsibility.

External Independent Medical Review (Blue Shield Medicare Advantage HMO and PPO Plans)

For Blue Shield Medicare Advantage plan members, CMS has contracted with a national independent review body, MAXIMUS Federal Services, Inc. MAXIMUS Federal Services, Inc. is an independent CMS contractor that review appeals by members of Medicare managed care plans, including Blue Shield Medicare Advantage plan.

External Review

An option provided to commercial members for consideration of:

- A medical necessity decision following an appeal;
- An appeal under the Friedman/Knowles Experimental Treatment Act in which care for a member with a terminal illness has been denied on the grounds that the treatment is experimental;
- Where the case is sent to an independent, external review organization for an opinion, which is binding on Blue Shield.

Fee-for-Service

A payment system by Medicare. Fee-for-service doctors, hospitals, and other providers are paid for each service performed. For Blue Shield Medicare Advantage plan, this is also known as traditional or original Medicare.

FEP

The Federal Employee Program.

Formulary

A continually updated list of prescription medications that are approved by the Food and Drug Administration (FDA) and are selected based on safety, effectiveness, and cost for coverage under the Outpatient Prescription Drug program. The list is based on evidence-based review of drugs by members of the Blue Shield Pharmacy & Therapeutics Committee. This Committee is made up of physicians and pharmacists, including practicing network physicians and pharmacists who are not employees of Blue Shield, many of whom are providers and experts in the diagnosis and treatment of disease. The formulary contains both brand-name, generic and biologic drugs.

Fraud, Waste and Abuse (FWA)

Comprehensive program to detect, correct and prevent fraud, waste, and abuse in the Part D benefit.

Glossary

Grievance

An expression of dissatisfaction by a member, member representative or provider on the member's behalf, and categorized as a potential quality issue, appeal (*see Appeals*) or complaint.

Health Maintenance Organization (HMO)

A health care service plan that requires its members to use the services of designated physicians, hospitals, or other providers of medical care except in a medical emergency. HMOs have a greater control of utilization and typically use a capitation payment system.

Health Services Contract

The employer group or individual contract that establishes the benefits that subscribers and dependents are entitled to receive.

HIPAA (The Health Insurance Portability and Accountability Act of 1996)

HIPAA is the 1996 federal legislation that changes health coverage requirements in the group and individual markets. It contains provisions regarding portability of health coverage, Administrative Simplification, Medical Savings Accounts (MSAs), and fraud and abuse. The Centers for Medicare & Medicaid Services (CMS), formerly, is the main regulatory agency responsible for implementing the provisions of HIPAA. The provisions relating to Administrative Simplification were effective in 2002 and 2003. Administrative Simplification is intended to reduce the costs and administrative burdens of health care by establishing national standards (including security) and procedures for electronic storage and transmission of health care information. Administrative Simplification affects health plans, health care providers, and clearinghouses that transmit or collect health information electronically.

HIPAA EDI Validation Report

Blue Shield validates inbound electronic claim files for HIPAA compliance and produces a report to providers submitting electronic claims. Blue Shield utilizes Edifecs as its HIPAA validator.

Hold Harmless

An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed with a Blue plan as full payment for these services.

Home Health Care (HHC)

A comprehensive, medically necessary range of health services provided by a recognized provider organization to a patient at home, usually under the supervision of a physician.

Hospice Care

Care and services provided in a home or facility by a licensed or certified provider that is:

- Designed to be palliative and supportive care to individuals who are terminally ill, and
- Directed and coordinated by medical professionals authorized by the Plan

Hospital

- A licensed and accredited health facility engaged primarily in providing (for compensation from patients) medical, diagnostic, and surgical facilities for the care and treatment of sick and injured members on an inpatient basis, and that provides such facilities under the supervision of a staff of physicians and 24-hour a day nursing services by registered nurses (not including facilities that are principally rest homes, nursing homes, or homes for the aged),
- A psychiatric hospital licensed as a health facility and accredited by a CMS-approved accreditation agency, or
- A “psychiatric health facility” as defined in Section 1250.2 of the Health and Safety Code.

Hospitalist

A physician who specializes in the care of patients who are hospitalized.

In Area

Refers to services performed *within* the Blue Shield service area.

Independent Physician and Provider Agreement

A contract between Blue Shield and an individual physician or provider, or a group of individual physicians or providers for the provision of health care services to Blue Shield members.

Individual Family Plan (IFP)

A health plan purchased to cover an individual or family, as opposed to a group plan. It differs from a group plan in the following respects: (1) the individual applying for IFP coverage is the contract-holder rather than the employer, (2) underwriting evaluation of a health statement ordinarily is required for everyone to be covered under an IFP contract, and (3) choice of plans is restricted to predetermined benefits.

Infertility

The member who has a current diagnosis of infertility and who is actively trying to conceive and has either:

1. A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
2. The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Initial Decision/Initial Determination

When a physician group, hospital or Blue Shield makes an initial determination for a requested service or a claim for services rendered.

Glossary

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.

Interchange Acknowledgment (TAI)

For providers submitting electronic claims, Blue Shield provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Limitations

Refers to services that are covered by Blue Shield but only under certain conditions.

Lock-In

A provision for an HMO that requires the member to obtain all medical care through Blue Shield except in the following situations:

- Emergency services, anywhere
- Urgently needed services outside of the service area and (under limited circumstances) inside the service area
- Referrals to non-plan providers or Away-from-Home care

Members that use non-plan providers, except under the conditions mentioned, will be obligated to pay for these services. Neither Blue Shield nor Medicare will pay for these services.

Marketplace Exchange

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards.

The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a federally facilitated Marketplace in any state that does not do so or will not have an operable Marketplace for the 2014 coverage year, as determined in 2013. MAXIMUS Federal Services, Inc. (Blue Shield Medicare Advantage plan only).

Maximum Enrollee Out-of-Pocket Costs (Blue Shield Medicare Advantage HMO and PPO Plans)

For Blue Shield Medicare Advantage plan members, the maximum out-of-pocket (MOOP) amount is the most that they will pay during the calendar year for in-network covered Medicare Part A and Part B services. Amounts paid for plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. If a Blue Shield Medicare Advantage plan member reaches this amount, they will not have to pay any out-of-pocket costs for the remainder of the year for covered in-network Part A and Part B services. For specific guidelines on how to submit claims for MOOP electronically, contact the EDI Help Desk at (800) 480-1221.

MAXIMUS Federal Services, Inc. (Blue Shield Medicare Advantage HMO and PPO Plans)

An independent Centers for Medicare & Medicaid Services (CMS) contractor that review appeals by members of Medicare managed care plans, including Blue Shield Medicare Advantage plan.

Medicaid

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women. Medicaid is governed by overall Federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

Medical Necessity

See Section 3.

Medicare Advantage Organization (MAO)

A public or private entity that contracts with CMS to offer a Medicare Advantage plan. Blue Shield of California is a MAO that offers Blue Shield Medicare Advantage HMO and PPO plans.

Medicare Advantage (MA) Program

Section 4001 of the BBA created the MA Program as a new Part C of Title XVIII of the Social Security Act. On June 19, 1998, the Centers for Medicare & Medicaid Services (CMS), issued the regulation implementing the MA Program required by the BBA. Under this program, eligible individuals may elect to receive Medicare benefits through enrollment in one of an array of private health plan choices beyond the original Medicare program or the plans now available through managed care organizations.

Medicare-Covered Charges

The maximum amounts Medicare will pay for Medicare-covered services.

Glossary

Medicare Crossover

The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

Medicare Guidelines

The rules and regulations used by CMS to determine the services that Medicare covers under Part A (Hospital Insurance protection) and Part B (Medical Insurance protection).

Medicare Part D Covered Drug

A Part D covered drug is available only by prescription, approved by the Food and Drug Administration (FDA) (or is a drug described under section 1927(k)(2)(A)(ii) or (iii) of the Act), used and sold in the United States, and used for a medically accepted indication (as defined in section 1927(k)(6) of the Act). A covered Part D drug includes prescription drugs, biological products, insulin, and medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B as described in specified paragraphs of section 1927(k) of the Act, and vaccines licensed under section 351 of the Public Health Service Act. The definition of a covered Part D drug excludes any drug, biological product, insulin, or vaccine for which as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual. In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act. Medicare Part D excludes fees for drug administration, except for administration fees associated with the administration of a Part D vaccine.

Under Medicare guidelines, some drugs may be covered under Medicare Part B or Medicare Part D depending upon the characteristics of the beneficiary and/or medical use of the drug. This includes injectable drugs that are not usually self-administered. CMS' understanding that the practice of "brown-bagging" drugs is opposed by medical societies. CMS continues to urge providers to reinforce this message to their members. In essence, if the injection is administered to the member or dispensed within the four walls of a provider's office or facility, it is a Part B medication. In addition, member's share of cost for these types of medications are usually higher under Part D due to the tiering structure of the plan and are not eligible for tier exceptions. Unless otherwise indicated in the Division of Financial Responsibilities, Medicare Part B Covered Services are Group responsibility and Medicare Part D Covered Services are Blue Shield responsibility. Group is delegated for authorization of Medicare Part B drugs. If a drug does not meet LCD Medicare Part B coverage guidelines, Blue Shield will review for potential coverage under Part D, using the LCD Medicare guidelines and Blue Shield prior authorization coverage criteria. An LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).

Medicare Supplemental (Medigap)

Medicare Supplemental (Medigap) pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the “gaps” in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan does not cover.

Medigap policies are regulated under federal and state laws and are “standardized.” There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member’s Home Plan via Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments, or other cost-sharing.

Member

An individual, either a subscriber or eligible dependent, who is enrolled and maintains coverage in a Blue Shield Plan under the health services contract. This term also applies to Medicare beneficiaries enrolled in the Blue Shield Medicare Advantage plan or a Blue Shield Medicare prescription drug plan.

National Account

An employer group with employee and/or retiree locations in more than one Blue plan’s service area.

National Drug Code (NDC)

The National Drug Code (NDC) is a universal number that identifies a drug or a related drug item. The NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2-digit format.

National Provider Identifier (NPI)

The NPI is a unique 10-digit numeric identification number. The NPI will be issued by CMS to all eligible health care individual practitioners, groups, and facilities. The NPI is required on all HIPAA compliant standard electronic transactions.

Non-Covered Services

Health care services that are not benefits under the subscriber’s *Evidence of Coverage/ Disclosure Form*.

Glossary

Opt-Out

The act of a member seeking care without a referral from the primary care physician. Depending upon which type of HMO plan involved, opt-outs might or might not be covered. If covered, members who opt out are responsible for higher out-of-pocket costs. Also called "self-referral."

Other Party Liability (OPL)

A cost containment program that ensure Blue plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers' Compensation, subrogation, and no-fault auto insurance.

Out-of-Area Follow-up Care

Out-of-area services which are non-emergent and medically necessary in nature to establish the member's progress following an initial emergency or urgent service.

Out-of-Pocket Maximum

The highest deductible, copayment and coinsurance amount an individual or family is required to pay for designated covered services each year as indicated in the *Summary of Benefits*. Charges for services that are not covered and charges in excess of the allowable amount or contracted rate do not accrue to the out-of-pocket maximum.

Note: Members are financially responsible for any services which are not covered by the Plan. This may result in total member payments in excess of the out-of-pocket maximum.

Outpatient

An individual receiving services under the direction of a plan provider but not requiring hospital admission.

Note: For Blue Shield Preferred Plans, a length of stay past midnight is considered an inpatient admission.

Outpatient Facility

A licensed facility, not a physician's office or a hospital, which provides medical and/or surgical services on an outpatient basis.

Part B Premium (Blue Shield Medicare Advantage HMO and PPO Plans)

A monthly premium paid (usually deducted from a person's Social Security check) to cover Part B Premiums for Original Medicare fee-for-service. Members of Blue Shield Medicare Advantage plans must continue to pay this premium by themselves, Medicaid, or another third party, to receive full coverage and be eligible to join and stay in Blue Shield Medicare Advantage plan.

Part D Premium (Blue Shield Medicare Advantage HMO and PPO Plans)

Referred to as the Income Related Medicare Adjustment Amount (IRMAA). Beginning in 2011, the Affordable Care Act requires Part D enrollees whose incomes exceed certain thresholds, pay a monthly adjustment amount. This new premium applies to all Medicare beneficiaries, both group and individual, who fall into higher income levels. Like Part B, the premium will usually be deducted from the person's Social Security check.

Participating Provider

A provider who has contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members enrolled in a designated Plan. This definition does not include providers who contract with Blue Shield's mental health service administrator (MHSA) to provide covered mental health and substance use disorder services.

Payor

The entity that accepts the financial risk for the provision of health care services.

Peer Review

A physician review for the purposes of determining the existence of an actual or potential quality of care issue. This review process includes a review of the clinical and administrative information available. It is the evaluation or review of the performance of colleagues by professionals with similar types and degrees of expertise.

Percent of Billed Charges

A payment arrangement under which a provider is reimbursed at a previously agreed upon percentage of the total billed amount, not to include non-benefit items or items previously excepted from the payment arrangement.

Per Diem Rate

A negotiated rate per day for payment of all covered inpatient services provided to a patient in a preferred hospital.

Physician Advisor Review

A physician review of a utilization management request for prospective, concurrent and/or retrospective reviews for the purpose of determining medical necessity and/or appropriateness of care or services.

Place of Care

The options for the physical location in which a medication can be administered. Places of care include the physician's office, outpatient facility, ambulatory infusion center or home health/home infusion.

Plan

The member's health care service plan, e.g., HMO, PPO, EPO, and POS.

Glossary

Plan Hospital

A hospital licensed under applicable state law contracting with Blue Shield specifically to provide HMO Plan benefits to members.

Plan Provider

A provider who has an agreement with Blue Shield to provide covered services to HMO members.

Plan Specialist

A physician (M.D. or D.O.) other than a primary care physician, who has an agreement with Blue Shield to provide covered services to HMO members according to an authorized referral by a primary care physician, or according to the Access+ Specialist program, or during a well-woman examination.

Point-of-Service (POS)

A type of managed care plan whereby members have the option of choosing to obtain covered medical services from the provider of their choice from a provider within Blue Shield network or from an out-of-network provider, or through their primary care physician who manages their care and refers members to participating hospitals, physicians, and other providers within a select HMO network. POS members who obtain their medical care through their primary care physician receive HMO level benefits. Members who self-refer to in-network or out-of-network providers are subject to applicable deductibles, copayments, and coinsurance. Care received from out-of-network providers is covered at the lowest benefit level. When members receive services from out-of-network providers they are financially responsible for the difference between the amount Blue Shield allows for those services and the amount billed by the out-of-network provider. Mental health and substance use disorder services are provided at the HMO and PPO non-participating levels of care.

Pre-Existing Condition

Any physical and/or mental illness, injury or condition or conditions that existed during the 12 months prior to the effective date of coverage if, during that time, (1) any professional advice or treatment, or any medical supply (including but not limited to prescription drugs or medicines) was obtained for that disability, or (2) there was the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment.

Preferred Provider Organization (PPO)

A network of providers (usually physicians, hospitals, and allied health care professionals) that contract with a payor to deliver services to the enrollees of a designated health care service plan. These providers agree to accept the payor's allowances plus any enrollee coinsurance, copayment, or deductible as payment in full.

Preferred Provider Organization, Basic (PPOB)

A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.

Prefix

Three characters preceding the subscriber identification number on the Blue plan ID cards. The prefix identifies the member's Blue plan or national account and is required for routing claims.

Prescription Drug Plan (PDP)

Medicare Part D prescription drug coverage that is offered under a policy, contract or plan that has been approved by the Centers for Medicare & Medicaid Services (CMS) as specified in 42 C.F.R. § 423.272 to offer qualified prescription drug coverage.

Primary Care Physician (PCP)

A general practitioner, board-certified (if not board certified, must at least have completed a two-year residency program) eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with Blue Shield to provide Covered Services to members in accordance with their health services contract and the Plan service delivery guidelines.

Primary Care Physician (PCP) Behavioral Health Toolkit

Blue Shield's new online toolkit designed specifically for primary care providers to help them manage or coordinate their patients' behavioral health needs. Providers can log into www.blueshieldca.com/provider, select the *Guidelines & Resources* tab, then click *PCP Behavioral Health Toolkit* in the *Patient Care Resources* section to find information for managing a behavioral health condition or making a referral to a behavioral health provider, as well as consultation contact information, patient educational materials, and more.

Provider/Practitioner

A credentialed health care professional or facility that has an agreement with Blue Shield to provide services to members.

Provider Connection

Blue Shield's provider website at www.blueshieldca.com/provider.

Provider Inquiry

A telephoned or written request from a provider to explain the rationale for a decision to reduce, delay, or deny services or benefits. This inquiry may or may not alter the original decision.

Glossary

Provider Manual

The Blue Shield *Independent Physician and Provider Manual*, which sets forth the operational rules and procedures applicable to Blue Shield physicians and providers and which is amended and updated by Blue Shield at least annually. The Provider Manual shall include the Bylaws and rules, regulations or policies adopted by Blue Shield, including Blue Shield's payment and medical policies, which may, from time to time, be communicated to physicians and providers.

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- A) An immediate danger to himself or to herself, or to others.
- B) Immediately unable to provide for, or utilize, food, shelter, or clothing due to the mental disorder.

Qualified Health Plan (QHP)

Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Quality Improvement Organization (QIO)

A group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare. QIOs work under the direction of the Centers for Medicare & Medicaid Services (CMS) to assist Medicare providers with quality improvement and to review quality concerns for the protection of beneficiaries and the Medicare Trust Fund. Formerly known as a Peer Review Organization (PRO). Health Services Advisory Group (HSAG) is the QIO for California.

Reasonable Layperson

A non-medically trained individual using reasonable judgement under the circumstances. For emergency services, coverage is provided when a member would believe that an emergency situation exists.

Referral

The process by which a provider refers a member to another provider for covered services.

Referred Services

A covered health service, performed by a referred-to provider, which is:

- Authorized in advance by the primary care physician and/or the IPA/medical group
- Limited in scope, duration, or number of services, as authorized

Referred-To Provider

A provider to whom a member is referred for services.

Rehabilitation Service

Inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illness and Severe Emotional Disturbances of a Child, to restore an individual's ability to function to the maximum extent practical. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

Residential Care

Mental Health and Substance Use Disorder services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for members who do not require acute inpatient care.

Secure File Transfer Protocol (SFTP)

A service (communication protocol) specially designed to establish a connection to a particular computer, so that files can be securely transferred between computers. This protocol encrypts the data transferred to the receiving computer and prevents unauthorized access during the operation.

Service Area (Blue Shield Medicare Advantage HMO and PPO plans)

The geographic area in which a person must permanently reside in to be able to become or remain a member of a Blue Shield Medicare Advantage plan. Blue Shield Medicare Advantage plans have multiple service areas within California. The specific service area in which the member permanently resides determines the Medicare Advantage plan(s) in which they may enroll. More than one Blue Shield Medicare Advantage plan may be offered in a service area.

Service Area (HMO)

The geographic area as defined in the Blue Shield HMO contract generally considered to be located within a 30-mile radius from the IPA/medical group's primary care physician facilities.

If members receive care outside their primary care physician's service area, it must be for an urgent or emergency condition or authorized by their primary care physician. When processing claims and encounters, the zip code of the attending physician (for professional claims) or the billing provider (for facility claims) is compared to the IPA/medical group's table of zip codes stored in Blue Shield's system to determine if the claim is for out-of-area services.

Shared Savings Services

Covered services paid by Blue Shield from a budget that is subject to a periodic settlement. Any surplus or deficit from this budget is shared between the IPA/medical group and Blue Shield.

Glossary

Skilled Nursing Facility (SNF)

A facility with a valid license issued by the California Department of Public Health as a “Skilled Nursing Facility” or any similar institution licensed under the laws of any other state, territory, or foreign country. Also included is a Skilled Nursing Unit within a Hospital.

State Children’s Health Insurance Program (SCHIP)

SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

Stop-Loss

A contractual agreement with day or dollar threshold criteria that allows payment beyond the normal case or per-diem rate.

Sub-Acute Care

Skilled nursing or skilled rehabilitative care provided in a hospital or skilled nursing facility to patients who require skilled care such as nursing services; physical, occupational, or speech therapy; a coordinated program of multiple therapies; or who have medical needs that require daily monitoring by a registered nurse. A facility that is primarily a rest home, convalescent facility, or home for the aged is not included in this definition.

Subscriber

A group employee or individual who is enrolled in and maintains coverage under the health services contract.

Third Party Liability

A provision of the health services contract that allows recovery of reasonable costs from a third party when a member is injured through the act or omission of a third party.

Traditional Coverage

Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance, or copayments.

Urgent Services (HMO/POS Members)

Those covered services rendered outside of the primary care physician’s service area (other than Emergency Services) which are medically necessary to prevent serious deterioration of a member’s health resulting from unforeseen illness, injury, or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the member returns to the primary care physician’s service area.

Validation Reports

Blue Shield generates a validation report for electronic submitters of claims and encounters summarizing the number of claims and encounters that have been received and processed.

Waivered Condition

A condition that is excluded from coverage for charges and expenses incurred during the six (6) month period beginning as of the effective date of coverage. A Waivered Condition applies only to a condition for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended, or received from a licensed health practitioner during the six (6) months immediately preceding the effective date of coverage.

Glossary

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Blue Shield Combined Eligibility/Capitation Report

COMMERCIAL

FIELD NAME	NOTES	FIELD LENGTH
CapitatedEntity		12
CapitatedEntityEffDate		10
CapitatedEntityCancelDate		10
ActivityType	A, T, R, C, blank	9
MemberLastName		35
MemberFirstName		15
MemberMiddleInitial		1
MemberCertNumberCurrent	Sub ID + SFX	14
MemberCertNumberPrevious		14
MemberRelationship	E, S, D	1
MemberAddressLine1		40
MemberAddressLine2		20
MemberAddressLine3		20
MemberCity		20
MemberState		2
MemberZipCode		10
MemberPhoneNumber		20
MemberGender		1
MemberAge		3
MemberDateOfBirth		10
MemberLanguagePref		4
SubscriberSsn		9
PCPID		12
NPIforPCP		10
PCPName		55
PCPEffDate		10
PCPCxlDate		10
GroupID		8
GroupName		50
GroupType		10
GroupEffDate		10
GroupRenewalDate		10
ProductID		8
ProductIdDescription		115
ProductIdEffDate		10
PlanID		8
PlanName		70
NetworkId		12
AlphaPrefix		4
ClassId		4

Blue Shield Combined Eligibility/Capitation Report

FIELD NAME	NOTES	FIELD LENGTH
LineOfBusinessId		4
LineOfBusinessDescription		50
CostAccountingCategory		3
OfficeVisitCopayAmount		3
IndivDeductibleAmount		7
FamilyDeductibleAmount		7
CobFlag		1
CobOrder		1
CobEffDate		10
CobTermDate		10
CobOtherCovId		9
CobOtherCovDescription		50
EarnedDate		10
CapitationAmount		11
AdminFeeAmount		11
OtherPayAmount		11
MemberMonths		11
ReasonCode		4
GroupCapConvertDate		10
SubConvertDate		10
SrcSysId	FACETS	10
Grace Period Start Date		10
Grace Period End Date		10
Grace Period Suspended Date		10
Anticipated End Date if no payment		10

Blue Shield Combined Eligibility/Capitation Report

MEDICARE

Field Number	FieldName	FiedDesc	Format (if applicable)	Max Length	Data Type	Prior Field Name (If applicable)	Notes
1	CapitatedEntity	BSC Facets IPA number		12	Text	IPA_Code	Medicare Site IDs are now identical to the equivalent 12 character commercial IDs
2	CapitatedEntityEffDate	Member effective date with IPA	YYYY-MM-DD	10	Date	IPA_Eff_Date	
3	CapitatedEntityCancelDate	Member cancel date with IPA	YYYY-MM-DD	10	Date	IPA_Cancel_Date	
4	ActivityType	A, R, C, T, Blank		2	Text	Activity	Medical Group R = Member added then terminated from the IPA Medical Group for the purpose of paying retro capitation C = Change in assigned PCP, no change to assigned IPA T = Member terminated from the IPA Medical Group Blank = Member continues eligibility with no changes
5	MemberLastName	Member last name		35	Text	Last_Name	
6	MemberFirstName	Member first name		15	Text	First_Name	
7	MemberMiddleInitial	Member middle initial		1	Text		
8	MemberCertNumberCurrent	BSC member ID	NNNNNNNNN-NNN	13	Text	Member_No	Same format as commercial ID
9	MemberCertNumberPrevious	Previous BSC member ID		14	Text	Prior_Mbr#	Legacy system ID (if available)
10	MemberAddressLine1	Member address		40	Text	Street_Address	
11	MemberAddressLine2	Member address		40	Text		
12	MemberAddressLine3	Member address		40	Text		
13	MemberCity	Member city		20	Text	City	
14	MemberState	Member state		2	Text	State	
15	MemberZIPCode	Member ZIP		5	Text	ZipCode	
16	MemberPhoneNumber	Member phone number		20	Text	Phone_No	
17	MemberGender	Member gender		1	Text	Sex	
18	MemberAge	Member age	0	3	Number	Age	
19	MemberDateOfBirth	Member date of birth	YYYY-MM-DD	10	Date	DOB	
20	MemberLanguagePref	Member language (ie EN, SP)		4	Text	e	
21	HICN	Medicare (CMS) Health Insurance Number (HICN)		12	Text		CMS HICN number
22	PcpID			12	Text	PCP_No	Same format as commercial PCP ID, for capitated hospital, this field contains the IPA number, not PCP
23	NPIforPCP			10	Text	NPI	
24	PcpName			55	Text	PCP_Name	Name, for capitated hospital, this field contains the IPA name, not PCP
25	PcpEffDt		YYYY-MM-DD	10	Date	PCP_Eff_Date	

Blue Shield Combined Eligibility/Capitation Report

Field Number	FieldName	FiedDesc	Format (if applicable)	Max Length	Data Type	Prior Field Name (If applicable)	Notes
25	PcpEffDt		YYYY-MM-DD	10	Date	PCP_Eff_Date	
26	PcpCxlDt		YYYY-MM-DD	10	Date	PCP_Cancel_Date	
27	GroupID			8	Text	Group_ID	GroupID for IMAPD, GroupID for GMAPD will be the same as the commercial Facets ID (if any).
28	GroupName			50	Text		Employer group name
29	ProductID			8	Text	Current_Coverage_Code	ProductID varies by county for IMAPD and by employer group for Group Medicare.
30	ProductIDDescription			115	Text	Current_Coverage_Desc	Text field describes product IMAPD or GMAPD
31	ProductIDEffDate		YYYY-MM-DD	10	Date	if	
32	PlanID			8	Text		
33	PlanName			70	Text		
34	NetworkID	MGMAPD000001 - Group Medicare Advantage MIMAPD000001 - Blue Shield 65 Plus MIMAPD000002 - Blue Shield 65 Plus Choice		12	Text		12 character network ID identifies Group, Individual, or Choice Medicare
35	OfficeVisitCopayAmount		0	3	Number	Office_Copay_Amt	
36	MedicaidStatus	or N Indicates other coverage		1	Text	Medicaid_Status	
37	CobFlag	Y or N		1	Text		
38	CobOtherCoverageDescription			50	Text	Other_Coverage_ID	CIGNA, BLUE CROSS etc. if available)
39	EarnedDate		YYYY-MM-DD	10	Date	SVC_Month_paid	
40	CapitationAmount		0.00	18	Currency	Capitation_Amount	Core capitation payment
41	AdminFeeAmount		0.00	18	Currency	Admin_Amount	Admin fee (if any)
42	OtherPayAmount		0.00	18	Currency	Other_Cap_Amount	Medicare Advantage premium (if any).
43	ReasonCode	One adjustment code i.e. 42 Two adjustment codes i.e. 10, 08		10	Text		All HCFA 2 digit adjustment reason codes that occur in a given payment month
44	RiskScore	CMS risk score i.e. 1.089	NN.DDDD	7	Number	Risk_Scores	
45	CountyCode	CMS county code i.e. 200	NNN	3	Text	County_Code	
46	StateCode	CMS state code i.e. 05	NN	2	Text	State_Code	
47	MedicaidAddOn	Y or N i.e. E would indicate ESRD, H for Hospice		1	Text	Medicaid_Add-On	used in calculating the risk score, i.e., at least a one month period of Medicaid eligibility during the data collection period was established in CMS systems at the time that risk scores were calculated.
48	HealthStatus			10	Text	Health_Status	
49	ExceptionCode	T or blank		1	Text	Exception_Code	capitation if HCFA risk, health status or Demo code unavailable or in dispute)
50	MemberMonthCount	1, or -1		2	Number	Member_Month_Count	Indicates 1, -1 for events equating to a full member month being added or backed out.

Blue Shield HMO Eligibility Adds and Terminations Report

FIELD NAME	NOTES	FIELD LENGTH
CapitatedEntity		12
CapitatedEntityEffDate		10
CapitatedEntityCancelDate		10
ActivityType	A, T, R, C, blank	9
MemberLastName		35
MemberFirstName		15
MemberMiddleInitial		1
MemberCertNumberCurrent	Sub ID + SFX	14
MemberCertNumberPrevious		14
MemberRelationship	E, S, D	1
MemberAddressLine1		40
MemberAddressLine2		20
MemberAddressLine3		20
MemberCity		20
MemberState		2
MemberZipCode		10
MemberPhoneNumber		20
MemberGender		1
MemberAge		3
MemberDateOfBirth		10
MemberLanguagePref		4
SubscriberSsn		9
PCPID		12
NPIforPCP		10
PCPName		55
PCPEffDate		10
PCPCxlDate		10
GroupID		8
GroupName		50
GroupType		10
GroupEffDate		10
GroupRenewalDate		10
ProductID		8
ProductIdDescription		70
ProductIdEffDate		10
PlanID		8

Blue Shield HMO Eligibility Adds and Terminations Report

FIELD NAME	NOTES	FIELD LENGTH
PlanName		70
NetworkId		12
RiderCode	may not be available	
ClassId		4
LineOfBusinessId		4
LineOfBusinessDescription		50
CostAccountingCategory		3
OfficeVisitCopayAmount		3
IndivDeductibleAmount		7
FamilyDeductibleAmount		7
CobFlag		1
CobOrder	P/S different than Legacy	1
CobEffDate		10
CobTermDate		10
CobOtherCovId		9
CobOtherCovDescription		50
GroupCapConvertDate		10
SubConvertDate		10
SrcSysId	FACETS	10