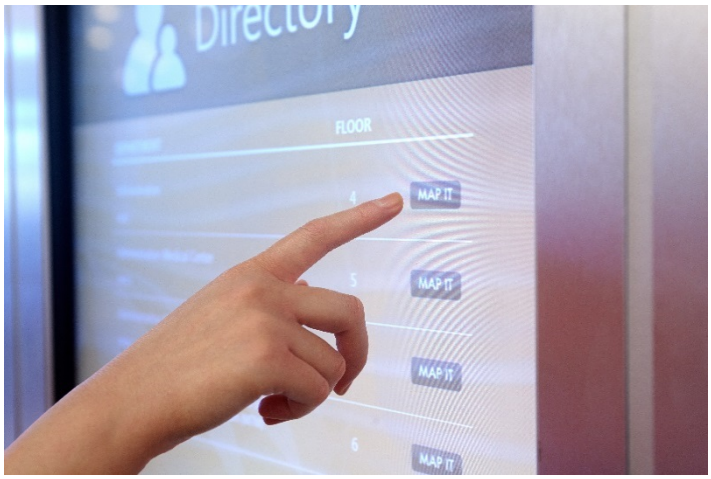
Kaiser Permanente Northwest Provider Manual 2018



Glossary of Terms

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A

Allowed amount

The maximum allowable benefits available under the plan. The allowed amount can be established by the practitioner/provider and Kaiser Permanente.

Appeal

A formal request by a practitioner or member to reconsider a decision made by the health plan. The appeal request may be related to a utilization management recommendation, benefit payment, administrative action against the practitioner or provider, or quality of care or service issue.

Authorization

A grant of approval to provide specific covered services.

B

Billed amount

Amount billed by the provider for a specific service.

Bundling

Occurs when two or more CPT-4 procedures are used to describe a procedure performed, when a single, more comprehensive, CPT-4 procedure code exists to accurately describe the entire procedure performed.

C

Capitation (CAP)

Capitation is a contracted per member per month (PMPM) dollar amount paid to a practitioner or provider to cover the cost of providing a specified scope of services. The provider is responsible for delivering (or arranging for the delivery of) all health services required by the covered person under the condition of the provider's contract.

Case management

Method of managing health care services for covered individuals with chronic, catastrophic, or ongoing health care needs, to develop and implement a plan that provides medically necessary quality care in a cost-effective environment.

Centers for Medicare & Medicaid Services

The federal agency responsible for administering Medicare and overseeing states' management of Medicaid. Formerly known as Health Care Financing Administration (HCFA).

Clean claim

A “clean” or “complete” claim is one with no defect or impropriety, including lack of required substantiating documentation from providers, suppliers, or members, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim.

Clearinghouse

A service bureau that handles electronic information routing.

Coinsurance

A form of cost-sharing where an insured individual pays a set percentage of the cost of covered health care services. The most common coinsurance involves the individual paying a fixed percentage (e.g., 20 percent) of the cost of a service.

Coordination of benefits (COB)

A way of determining the order in which benefits are paid and the amounts payable when a claimant is covered under more than one plan (individual or group). It’s intended to prevent duplication of benefits when someone is covered by multiple plans for medical, dental, or other care and treatment.

Covered services

Services covered under the terms of the contract between a carrier and a contract holder.

Copayments

A cost-sharing arrangement in which a member pays a specified charge for a specified service, such as $10 for an office visit. It’s usually due at the time the health care is rendered. Copayments are typically fixed or variable flat amounts for practitioner office visits, prescriptions, or hospital services.

D

Deductible

A fixed amount of money a member must pay for certain services in a calendar year before Kaiser will cover those services. Not all services are subject to a deductible. Services not subject to a deductible will be provided, minus any copayments or coinsurance, whether or not the insured person has met their deductible.

Diagnosis related groups (DRG)

Statistical system of classifying any inpatient stays into groups for purpose of payment. DRGs may be primary or secondary. The Centers for Medicare & Medicaid Services (CMS) uses this form of reimbursement to pay hospitals for Medicare recipients. Also used by a few states for all payers and by many private health plans for contracting purposes.

Durable medical equipment (DME)

Equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples include hospital beds, wheelchairs, and oxygen equipment.

E

Effective/eligibility date

The date a member becomes eligible for covered services under their health plan.

Electronic data interchange (EDI)

The exchange of data through electronic means rather than by paper or the phone.

Explanation of Benefits (EOB)

A written statement from an insurance company or third party payer that lists the amounts paid (or not paid/denied), based upon the member's benefit contract.

Explanation of Payment (EOP)

A written statement sent to the provider that lists the amounts paid (or not paid/denied), based upon the member's benefit contract.

F

Fee-for-service (FFS) reimbursement

The traditional health care payment system under which practitioners and other providers receive payment for services based on a contractually agreed-on fee schedule.

Formulary

A list of preferred drugs to be used as a guide for prescribing and dispensing pharmaceuticals.

G

Grievance procedure

The process by which a health plan member or participating provider can voice complaints and seek remedies.

H

Health Care Financing Administration (HCFA)

See *Centers for Medicare & Medicaid Services*.

Health Care Financing Administration Common Procedure Coding System (HCPCS)

A uniform coding method for health care providers and medical suppliers to report professional services, procedures, and supplies.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A federal law dealing with a variety of issues, including standardizing electronic health care transactions and the privacy and security of protected health information (PHI).

I

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

A coding system used by providers and the insurance industry to succinctly describe a patient's medical condition/diagnosis. These codes are also used in claims payment and medical management activities to review the appropriateness of treatment provided for a specific diagnosis.

Incidental procedure

A procedure carried out at the same time as a more complex primary procedure. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure. For these reasons, Kaiser Permanente won't reimburse an incidental procedure separately.

IntelliClaim

A code editor software application designed to evaluate professional and facility outpatient claims data, including HCPCS and CPT codes and associated modifiers.

L

M

Medicare Summary Notice

A written statement from Medicare that lists amounts paid (or not paid/denied), based on the member's Medicare eligibility and coverage under the federal Medicare program. Also known as Explanation of Medicare Benefits (EOMB).

Member

A person who meets all eligibility requirements of the applicable Kaiser Foundation Health Plan, who is enrolled in the plan, and for whom all required premiums have been paid. Members include subscribers and their dependents as defined in the Evidence of Coverage (EOC).

Membership Services Department

Kaiser Permanente staff who serve as a liaison between members and the rest of Kaiser Permanente. This department addresses questions about benefits and claims and resolves members' issues and concerns.

N

National Provider Identifier (NPI)

A standard unique 10-digit numeric identifier for all health care providers.

The NPI was mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Not covered amount

The amount billed by a provider for a service not covered due to limitations or exclusions from a member's benefit plan or provider reductions.

O

P

Patient responsibility

May include a portion of the amount listed in the "Not Covered Amount" column, any amount listed in "Applied to Deductible," and the "Copay/Coinsurance" columns on the Explanation of Payment.

Physical status modifiers

Should be appended to the CPT anesthesia code to distinguish between the various levels of complexity of anesthesia service(s) provided.

Preventive health services

Health care services designed for prevention and early detection of illnesses. These services generally include routine physical examinations, tests, and immunizations.

Provider Contracting & Relations

A department of internal and external representatives dedicated to serving Kaiser Permanente's provider networks. Responsibilities include provider contracting, reimbursement, provider office visits, training office staff, communicating Kaiser Permanente administrative policies and procedures, and resolving problems on behalf of providers.

R

S

T

U

Unbundling

The practice of a provider billing for multiple components of service previously included in a single fee.

Urgent care

Services needed to prevent serious deterioration of health from an unforeseen condition or injury (e.g., sore throats, fever, lacerations, and broken bones).

Utilization management

Evaluating the appropriateness of utilizing medical care services against the member's benefit plan, to ensure effective use of resources. Includes pre-authorization of services (before the service is obtained), concurrent review of services (while the service is being provided), retrospective review (after the service has been rendered), discharge planning, and case management.