Reimbursement Policy Definitions

These are standard terms used within the majority of our reimbursement policies. For specific policy-related definitions, please view the individual policy.

- **Authorization (Precertification):** An approval process for requested medical services, either by the healthcare provider or the patient, to determine if a request is covered for reimbursement. Authorization or precertification is determined by eligibility, plan benefits and medical necessity of the service being requested.

- **Age Edit:** A procedure and/or service performed that is age-specific (e.g., circumcision of a newborn).

- **Benefits:** Determination of which services rendered will be reimbursed by an insurance plan. Services will be reimbursed at a portion of the cost as determined by the contracted rates. These services include hospitalization, diagnostic tests, services rendered by health care providers, durable medical equipment and prescriptions.

- **Bundled Service:** An individual service that is included in a more complex or comprehensive service and billed on the same date of service as the more comprehensive service.

- **Code Editing Logic:** A review and evaluation tool for accuracy and adherence of medical claims to accepted national industry standards, plan benefits and authorization guidelines.

- **Code Set:** “Any set of codes used for encoding data elements such as tables of terms, medical concepts, medical diagnostic codes or medical procedure codes.” (HIPAA P.L. 104-191)

- **Consistency Guidelines:** System logic that identifies services that are inconsistent in nature, including gender-specific services provided to a member of the opposite sex; age-specific services provided to a member not in the appropriate age range; and surgical procedures performed on a member who previously has had the respective organ or only body part of that kind removed.

- **Covered Services:** Health care services the contractor provides to enrollees, including all services required by contract, state and federal law, and all additional services described by the contractor.

- **Duplicative Service Edit (Lifetime Max):** A procedure and/or service performed on a patient who has previously had that organ removed.

- **Encounter:** Record of a medically related service (or visit) rendered by (a) provider(s) to a beneficiary who is enrolled in a participating health plan during the date of service. It includes (but is not limited to) all services for which the health plan incurred any financial responsibility.

- **Fee Schedule:** A list of pre-established allowances for specific services.

- **Gender Edit:** A procedure and/or service performed that is gender-specific (e.g., hysterectomy on a female).

- **Global Allowance:** Reimbursement for certain services or surgical procedures that are considered to be directly related to a procedure’s global allowance will be considered integral/inclusive to that service and are not allowed separate reimbursement. Reimbursement for surgical procedures includes the pre-operative services, surgical operation and uncomplicated postoperative care visits.
Incidental Procedure: An incidental procedure is performed at the same time as a more complex primary procedure. The incidental procedure requires minimum additional resources and/or is clinically integral to the performance of the primary procedure. Procedures that are considered incidental when billed with related primary procedures on the same date of service will be denied.

Institutional Provider: A hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in a health insurance policy.

Level of Care: The intensity of professional medical care required to achieve the treatment objectives for a specific episode of care.

Medical Necessity Criteria: Clinical determinations to establish a service or benefit that will or is reasonably expected to:
- Assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities appropriate for individuals of the same age
- Prevent the onset of an illness, condition or disability
- Reduce or ameliorate the physical, mental, behavioral or developmental effects of an illness, condition, injury or disability

Medical Records: Reports, notes, photographs, X-rays or other recorded data or information (whether maintained in written, electronic or another form) that are received or produced by a health care provider or any person employed by the provider. These items contain information relating to the medical history, examination, diagnosis or treatment of the member for an identified episode of care for specific dates of service.

Modifier: “A modifier is a two-digit numeric or alphanumerical character reported with a Healthcare Procedure Coding System (HCPCS) code when appropriate. Modifiers are designed to give Medicare and commercial payers additional information needed to process a claim. This includes HCPCS Level I (Physicians’ Current Procedural Terminology [CPT]) and HCPCS Level II codes. A modifier provides the means by which a physician or facility can indicate or ‘flag’ a service provided to the patient that has been altered or affected by some special circumstances, but for which the basic code description itself has not changed.” [Ingenix Learning: Understanding Modifiers, 2008 ed]

Mutually Exclusive Procedures: Two or more procedures that differ in technique or approach but lead to the same outcome; an initial service and subsequent service are considered mutually exclusive.

Recoup Payments: Retraction of monies paid to providers from future payments.

Recover Payments: Request for provider to return payment to Amerigroup.

Routine Medical and Surgical Supplies: Those that are customarily used in small quantities, are usually included in the staff’s supplies and not designated for a specific patient. Examples of routine medical supplies include gloves, cotton balls and certain incontinence supplies.

Unbundled Services: Individual procedure codes are billed when it is more appropriate to bill a single comprehensive code that indicates the specific group of procedures was performed (bundled service).