**Abuse**

Abuse involves provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid or CHIP programs including administrative costs from acts that adversely affect providers or members, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of health care; it also includes member practices that result in unnecessary costs to the Medicaid or CHIP programs.

**Abuse or Neglect (CPS)**

‘Abuse’ includes the following acts or omissions by a person:

- Mental or emotional injury to a child that results in an observable and material impairment in the child’s growth, development, or psychological functioning
- Causing or permitting a child to be in a situation in which a mental or emotional injury that results in an observable and material impairment in growth, development, or psychological functioning
- Physical injury that results in substantial harm to a child, or the genuine threat of substantial harm from physical injury, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm
- Failure to make a reasonable effort to prevent an action by another person resulting in physical injury is sustained results in substantial harm to the child;
- Sexual conduct harmful to a child’s mental, emotional, or physical welfare, including conduct that constitutes the offense of continuous sexual abuse of a young child or children, indecency with a child, sexual assault or aggravated sexual assault
- Failure to make a reasonable effort to prevent sexual conduct harmful to a child;
- Compelling or encouraging a child to engage in sexual conduct including conduct that constitutes an offense of trafficking of persons, prostitution or compelling prostitution
- Causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of a child if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene or pornographic;
- The current use by a person of a controlled substance in a manner or to the extent that the use results in physical, mental, or emotional injury to a child;
- Causing, expressly permitting, or encouraging a child to use a controlled substance
- Causing, permitting, encouraging, engaging in, or allowing a sexual performance by a child
- Knowingly causing, permitting, encouraging, engaging in, or allowing a child to be trafficked in a manner punishable as an offense or the failure to make a reasonable effort to prevent a child from being trafficked in a manner punishable as an offense
Abuse, Neglect or Exploitation (APS)
Abuse, neglect or exploitation includes the failure of one’s self to provide the protection, food, shelter, or care necessary to avoid emotional harm or physical injury or a negligent act or omission that caused or may have caused emotional harm, physical injury, or death.

Active Course of Treatment
Medical care in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits to the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol.

Acute Care Hospital
An institution providing medical care and treatment to sick and/or injured persons who cannot be cared for at a lower level of care (such as at a home or skilled nursing facility).

Acute Condition
A medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

Action (Medicaid Only)
The denial or limited authorization of a requested service, including the type or level of service:
• The reduction, suspension or termination of a previously authorized service.
• The denial, in whole or in part, of payment for a service.
• Failure to provide services in a timely manner and in time frames set by law.

Advance Directive
A legal document (health care instruction or power of attorney) used by persons to give their doctor instructions regarding their own health care if they cannot speak for themselves. Usually, the Advance Directive instructs physicians or other professional providers to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition, when the persons would be unable to make their wishes known at that time. All health care declarations are unconditionally revocable at any time, effective immediately upon communicating the change to the attending physician or health care provider.

Adverse Determination
A denial, modification, reduction or determination by BCBSTX or a PCP of a request for services based on eligibility, benefit coverage or medical necessity. Claims denials also are considered adverse determinations.
**Adverse Determination Appeal (CHIP only)**
The formal process by which a Utilization Review agent addresses an Adverse Determination.

**Adverse Determination Review (STAR only)**
A review and resolution of a provider claim payment after the Appeal or Expedited Appeal of an Adverse Determination.

**After-hours Services**
Services provided outside the PCP’s normal business hours.

**Ambulatory Care**
Health services that are on an outpatient basis, in contrast to services provided while confined at home or in a hospital.

**Ancillary Providers**
Providers who perform professional services such as laboratory tests and radiology exams.

**Appeal**
A request for review of an adverse determination.

**Appeal (Medicaid Only)**
The formal process by which a member, or his or her representative, requests a review of BCBSTX’s action, as defined above.

**Appellant**
A member, authorized representative or a treating physician or other professional provider who files an appeal of an Adverse Determination.

**Authorization**
Approval needed for members to receive certain types of specialty care and health services. The PCP or specialist can request authorizations for most health care services from BCBSTX.

**Authorized Representative**
Any person or entity acting on behalf of the member with the member’s written consent. A provider or physician may be an authorized representative.
Behavioral Health Services
Psychoanalysis, psychotherapy, counseling, medical management or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage and family therapist, for diagnosis or treatment of behavioral or emotional disorders or the behavioral or emotional problems associated with an illness, injury or any other condition.

Benefit Agreements
The Member Handbook, which describes and explains the health care benefits BCBSTX provides, indemnifies or administers for Members.

Benefit Year
The 12-month period from September 1 to August 31.

Benefits
The health, dental, vision and pharmacy services set forth in the Member’s benefit agreement.

Binding Arbitration
The process by which disputes are reviewed by a neutral, non-governmental entity. After reviewing all facts and hearing both sides, the neutral person/entity makes a decision.

Capitation
Capitation is the term for paying an organization a set amount of money in advance to provide comprehensive health care benefits for an individual.

Cardiopulmonary Resuscitation (CPR)
Artificial respiration and cardiac compressions.

Case Management
A process of arranging, negotiating and coordinating medically appropriate care in a more cost-effective and coordinated manner during prolonged periods of intensive medical care.

Carved-Out Services
Services that a BCBSTX Member is entitled to that are covered by the State of Texas, but are not covered under the BCBSTX benefit agreement.
Centers for Disease Control and Prevention (CDC)
The federal agency responsible for protecting the health and safety of people at home and abroad. The agency establishes and publishes immunization guidelines for children two years of age and under. These guidelines are a requirement for plan physicians and other professional providers, and are adopted by BCBSTX annually.

Centers for Medicare and Medicaid Services (CMS)
The federal agency responsible for the Medicaid health care program. CMS was formerly referred to as the Health Care Finance Administration (HCFA).

Children’s Health Insurance Program (CHIP)
The health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. 1397aa-1397jj) and administered by HHSC. The state of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate covered services for enrolled CHIP members.

Member Outreach
Local staff that provides members and community agencies ready access to BCBSTX’s staff, many of whom are bilingual and/or bicultural. The staff is also well acquainted with local community resources to assist members with their needs related to obtaining access to health care services and other needs.

Competent Interpreter
A person who is proficient in both English and the other language being used, has had orientation or training in the ethics of interpreting, including accuracy and impartiality in interpretation.

Complainant
A member or authorized representative who files a complaint.

Complaint Appeal
A written expression of dissatisfaction regarding a BCBSTX complaint resolution, not related to an Adverse Determination.

Complaint (CHIP only)
Any verbal or written dissatisfaction expressed to BCBSTX by a complainant regarding any aspect of BCBSTX’s operation including, but not limited to:
- Dissatisfaction with plan administration.
- Procedures related to the review or appeal process of an Adverse Determination.
- The denial, reduction or termination of a service for reasons not related to medical necessity.
**Complaint (Medicaid (STAR) only)**
A verbal or written expression of dissatisfaction expressed to BCBSTX by a complainant about any matter related to BCBSTX other than an Action. Possible subjects for complaints include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights.

**Concurrent Review**
The assessment of clinical information during the member’s current inpatient stay or ongoing course of medical service over a period of time.

**Consumer Assessment of Health Care Providers and Systems (CAHPS)**
A random survey of members to measure satisfaction with the service and care provided by BCBSTX and our primary care providers (PCPs) and specialists.

**Continued Access to Care**
The process of authorizing continuation of services with a terminating provider under specified conditions and for a limited period of time. This process involves having a plan of care to transition the member to a network physician or other professional provider.

The medical conditions that qualify for continued access to care include, but are not limited to:
- Second or third trimester of pregnancy through at least six weeks of postpartum evaluation
- Terminal illness
- A serious chronic condition

**Continuity of Care**
The coordination of health care services encompassing BCBSTX, PCPs, specialist physicians or other professional providers, ancillary providers and the member.

**Coordination of Benefits**
The method of determining primary responsibility for payment of benefits under the terms of the applicable benefit agreement and applicable laws and regulations, when more than one payer may be liable for payment of the member’s benefits.

**Coordination of Health Care Services**
The timely coordinated exchange of patient information between health care providers to help ensure delivery of an effective plan of treatment.
Copayment
A payment that a member makes at the time of receiving certain services, such as visits to a doctor and prescription drugs.

Corrective Action
A written plan from BCBSTX to a physician or other professional provider to remedy items that are out of compliance with BCBSTX’s standards and regulatory standards.

Coverage
The list of services for which benefits are available subject to deductibles, copayments or limitations from a health plan.

Covered Billed Charges
The charges billed by a provider or hospital at normal rates for services covered by the Benefit Agreement under which a claim is submitted.

Credentialing
The process of validating professional or technical competence of physicians or other professional providers which involves verifying licensure, board certification, education and identification of malpractice or negligence claims through the applicable state agencies and the National Practitioner Data Base (NPDB).

Credentials Committee
A credentials committee reviews the credentialing files and determines the acceptance or denial of an applicant as a contracted physician or provider.
Critical Event or Incident

An event or incident that may harm, or create the potential for harm to, an individual. Critical events or incidents include:

- Abuse or Neglect (CPS);
- Abuse, Neglect, or Exploitation (APS);
- Unauthorized use of restraint, seclusion, or restrictive interventions;
- Serious injuries that require medical intervention or result in hospitalization;
- Criminal victimization;
- Unexplained death;
- Medication errors; and
- Other incidents or events that involve harm or risk of harm to a member.

Cultural Competence

A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among and between groups. This requires a willingness and ability to draw on community-based values, traditions and customs and to work with knowledgeable persons from the community in developing focused interventions, communications and other supports.
**Cultural Diversity**
Differences in race, ethnicity, language, nationality or religion among various groups within a community, organization or nation. A city is said to be culturally diverse if its residents include members of different groups.

**Cultural Sensitivity**
An awareness of the nuances of one’s own and other cultures an awareness that differences exist.

**Culture**
The shared values, norms, traditions, customs, arts, history, folklore and institutions of a group of people. It is a shared set of beliefs, assumptions, values and practices that determines how we interpret and interact with the world.

A listing of descriptive terms and identifying codes used nationwide for reporting medical, surgical and diagnostic services and procedures performed by physicians. CPT codes are updated annually in November by the American Medical Association.

**Customer Service**
BCBSTX Customer Service unit for members and providers. Representatives can answer questions on benefits, PCP assignments, and authorizations for care, eligibility and member information.

**Deferrals**
An action taken by us to:
- Delay a decision to approve, modify or deny a request for authorization of a covered service to receive additional documentation from the requesting provider, or
- Determine if other medical coverage exists that is primary to BCBSTX.

**Delegation of Credentialing**
The assignment of responsibilities to perform the process of credentialing to another party contracted with BCBSTX.

**Denial**
A decision by BCBSTX to deny coverage of a member representative’s or provider’s request for health care services.

**Discharge Planning**
The process of assessing the medical and psychosocial needs of members in an inpatient setting and arranging transfers, in-home support or linkage with community resources in preparation for release from the inpatient setting or a change in the level of care.
**Discrimination**
As used in this context, discrimination means treating a member differently from others in the provision of a health care service or access to a facility on the basis of race, color, creed, religion, ancestry, marital status, sexual orientation, financial status, national origin, age, sex, physical or behavioral disability, diagnosis or advance directive status.

**Disenrollment**
The process that ensues when a member’s entitlement to receive services from a health plan is terminated.

**Electronic Data Interchange (EDI)**
Also known as electronic billing, EDI is a computer-to-computer transfer of business-to-business document transactions and information. Many health care organizations and their business partners, including physicians, payers, vendors, and fiscal intermediaries, choose EDI as a fast, inexpensive and safe method for automating their cooperative business processes.

**Eligibility**
The determination of whether a person is a member on the date of service.

**Emergency Behavioral Health Condition**
Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson—a person possessing an average knowledge of health and medicine—(1) requires immediate intervention or medical attention without which members would present an immediate danger to themselves or others, or (2) which renders members incapable of controlling, knowing or understanding the consequences of their actions.

**Emergency Care**
The initiation of the emergency response system and/or the diagnosis and/or treatment of an emergency.

**Emergency Medical Condition**
A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical care could result in:
- Placing the patient’s health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious and/or permanent dysfunction of any bodily organ or part.
- Serious disfigurement.
- Other serious medical or psychiatric consequences.
- Serious jeopardy to the health of a pregnant member or their unborn child.
Emergency Services
Covered inpatient and outpatient services furnished by a provider who is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition or an emergency behavioral health condition, including post-stabilization care services.

Enrollment
The process by which an eligible beneficiary becomes a member of our plan.

Exclusion
A service or condition not covered by BCBSTX pursuant to the member’s benefit agreement.

Expedited Adverse Determination Appeal (CHIP only)
An appeal of an Adverse Determination related to the denials of:
- Emergency care.
- Care for life-threatening conditions.
- Continued stays for hospitalized members.

Expedited Appeal
An appeal to BCBSTX in which the decision is required quickly based on the member’s health status, and the amount of time necessary to participate in a standard appeal could jeopardize the member’s life, health or ability to attain, maintain or regain maximum function.

Explanation of Benefits
A form sent to the member or provider after a claim for payment has been processed by the health plan that explains the action taken on that claim. This explanation might include the amount paid, the benefits available and reasons for denying payment.

Family Planning Services
Services, supplies or medications provided to members of childbearing age to temporarily or permanently prevent or delay pregnancy. The following are not considered family planning services:
- Therapeutic abortion services
- Routine infertility studies or procedures to promote fertility
- Hysterectomy for sterilization purposes only
- Transportation, parking or child care

Fee Schedule
A listing of allowed charges or established allowances for specified procedures. It represents a provider’s or third party’s standard or maximum charges accepted or recognized for listed procedures.
Fraud
An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him- or herself or some other person; fraud includes any act that constitutes fraud under applicable federal or state laws and regulations.

Generally Accepted Standards of Medical Practice
Standards 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.

Health Care Effectiveness and Data and Information Sets (HEDIS®)
Measures include the review of administrative and chart data to determine how effective BCBSTX and its physicians/providers are in the provision of quality care and services to adults, children, pregnant women and persons with behavioral health illness.

Health and Human Services Commission (HHSC)
The administrative agency with the executive department of Texas state government established under Chapter 531, Texas Government Code or its designee, including, but not limited to, the Texas Health and Human Services Agency.

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA is designed to streamline health care delivery by employing standardized, electronic transmission of administrative and financial transactions, along with protection of confidential protected health information (PHI).

Health Plan Members
Eligible adults, adolescents, children and infants actively enrolled with BCBSTX.

High-Volume Specialists
Physicians, other than PCPs, determined by BCBSTX to treat a significant number of plan members (for example, OB/GYN physicians).

Hospital
A health care facility licensed by the State of Texas, and accredited by the Joint Commission on Accreditation of Health Care Organizations, as either (a) an acute care hospital; (b) a psychiatric hospital; or (c) a hospital operated primarily for the treatment of alcoholism or substance abuse. A facility which is primarily a rest home, nursing home or home for the aged, or a distinct part skilled nursing facility portion of a hospital is not included.
**Hospital Services**
Those acute care inpatient and hospital outpatient services which are covered by the benefit agreement. Hospital services do not include long-term non-acute care.

**Infection Control**
The processes used to prevent the spread of pathogenic disease.

**Infusion Therapy**
The therapeutic use of drugs or other substances ordered by a physician and prepared, compounded or administered by a qualified Provider and given to the patient any way other than by mouth, and all medically necessary supplies and durable medical equipment used in relation to the infusion therapy in any setting other than an acute inpatient hospital unit.

**Initial Health Assessment (IHA)**
A complete medical history, a head-to-toe physical examination, and an assessment of health behaviors. For children up to 20 years of age, a developmental history, assessment of nutritional status, dental evaluation, vision screening and hearing screening are required in addition to the physical examination. Age-appropriate preventive screening is included for both adults and children.

**Inpatient**
Hospitalization in a medical or psychiatric hospital for treatment requiring at least one overnight stay.

**Institutionalized**
Involuntarily or voluntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a behavioral hospital or other facility for the care and treatment of behavioral illness.

**Intermediate Rehabilitation Facility**
An institution providing an active dynamic program aimed at enabling an ill or disabled person to achieve the highest level of physical, mental, social and economic self-sufficiency of which he or she is capable.

**Internal Quality Improvement Projects**
These include focused studies that measure the quality of care and service in specified clinical and service areas. BCBSTX is required to demonstrate statistically significant improvement for all measures.

**Interpreter Services**
Language services provided to non-English speaking Members to help ensure clear communication between the Member, Provider and plan.
Licensed Clinical Social Worker (LCSW)
Behavioral health professionals licensed by the State of Texas who are trained to help individuals, groups, families and organizations deal with emotional problems and assist in resolving conflicts or problems relating to others at home, at work, in school and in society in general.

Managed Care Network (MCN)
The network of health care providers who have entered into contracts with us and/or one or more of our affiliates pursuant to which those providers have agreed to participate in our programs and provider services pursuant to the member’s benefit agreements.

Managed Care
A combined clinical and administrative approach that coordinates health care services. Managed care emphasizes preventive services and the use of a PCP.

Medical Information
Individually identifiable information in electronic or physical form, in possession of, or derived from a provider of health care, regarding a member’s medical history, behavioral or physical condition, or treatment.

Medical Office Equipment Requiring Calibration or Safety Checks
Equipment in a provider’s office for which the manufacturer, state or federal agency recommends or requires routine evaluation of the functioning, readings and settings.

Medical Record Review (MRR)
A process to assess provider documentation of a member’s physical and psychosocial assessments and the medical services rendered.

Medical Review
The process involving provider audits in which claims or procedures are evaluated for medical necessity.

Medical Services
Those services provided by a participating provider and covered pursuant to a member’s benefit agreement.
**Medically Necessary or Medical Necessity**

Medically Necessary means:

For Medicaid members from birth through age 20, the following Texas Health Steps services:

- Screening, vision, and hearing services; and

- Other health care services, including behavioral health services, that are necessary to correct or ameliorate a defect or physical or behavioral illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or behavioral illness or condition:
  - Must comply with the requirements of the Alberto N., et al. v. Suehs, et al. partial settlement agreements; and
  - May include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.

For Medicaid and CHIP members, non-behavioral health related health care services (that are not available to Medicaid members from birth through age 20 through Texas Health Steps) that are:

a. Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;

b. Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member’s health conditions;

c. Consistent with health care practice guidelines and standards endorsed by professionally recognized health care organizations or governmental agencies;

d. Consistent with the member’s diagnoses;

e. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

f. Not experimental or investigative, and

g. Not primarily for the convenience of the member or provider.

For Medicaid and CHIP members, behavioral health services (that are not available to Medicaid members from birth through age 20 through Texas Health Steps) that are:

a. Reasonable and necessary for the diagnosis and treatment of a behavioral health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

b. In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

c. Furnished in the most appropriate and least restrictive setting in which services can be safely provided;

d. The most appropriate level or supply of service that can be safely provided;

e. Could not be omitted without adversely affecting the member’s behavioral and/or physical health or the quality of care rendered;

f. Not experimental or investigative; and

g. Not primarily for the convenience of the member or the provider.
Medically Needy
A category of public assistance. These are families of people who are aged, blind or disabled, and whose income is too high to qualify for Temporary Assistance to Needy Families (TANF) or Supplemental Security Income/State Supplemental Program (SSI/SSP).

Member Complaint
A written or oral expression of dissatisfaction, including quality of care concerns, regarding a physician or other professional provider or member, and which includes a complaint, dispute, or request for appeal made by a member or the member’s representative. If BCBSTX is unable to determine whether the expression of dissatisfaction is a grievance or an inquiry, it shall be considered a complaint.

Member Identification Card
The identification card provided to members by BCBSTX that includes the member’s ID number, physician or other professional provider information and important phone numbers.

Members
Eligible beneficiaries who are enrolled with BCBSTX.

Members with Hearing Loss Services
A system of communication provided by us to facilitate communication between members with hearing loss and their primary care provider (PCP) or BCBSTX. These services include a sign language interpreter service for medical appointments. If one is not available in the physician’s office, access is available by calling BCBSTX Customer Service.

Members with Special Health Care Needs
Member, including a child enrolled in the DSHS CSHCN Program, who:
- Has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to last for a significant period of time, and
- Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

Mental Health Targeted Case Management
Services designed to assist members with gaining access to needed medical, social, educational, and other services and supports. Members are eligible to receive these if they have been assessed and diagnosed with a severe and persistent mental illness (SPMI) or a severe emotional disturbance (SED) and they are authorized to receive mental health rehabilitative services.
Mid-Level Practitioners
Advanced registered nurse practitioners (including certified nurse midwives), and physician assistants licensed by the state and working under the supervision of a licensed physician as mandated by state and federal regulations.

Minor Consent Services
Services a minor can consent to without parental involvement. In Texas, these services include, but are not limited to:
- Family planning
- Prenatal care
- STD and HIV treatment
- Drug or alcohol abuse treatment
- Behavioral health services
- Abortion (with a court order)

National Committee for Quality Assurance (NCQA)
An independent, nonprofit organization whose mission is to improve the health care quality of the nation’s managed care plans through their accreditation and performance measurement programs. This is accomplished through quality oversight and improvement initiatives at all levels of the health care system.

Serious Reportable Events
As defined by the National Quality Forum (NQF), adverse events that are serious, but largely preventable, and of concern to both the public and health care providers.

Outpatient Hospital Services
Diagnostic, therapeutic, and rehabilitative services provided to members in an organized medical facility, for less than a 24-hour period, by or under the direction of a physician or other professional provider.

Participating Hospital
A hospital that has entered into an agreement with BCBSTX to provide hospital services as a participating provider.

Participating Physician or other Professional Provider
A physician or other professional provider who has entered into an agreement with BCBSTX to provide medical services as a participating Provider.

Participating Provider
A health facility or health professional that has entered into an agreement with BCBSTX to provide covered services to members.
Physician or Professional Provider Complaint
A written request for a formal investigation into an issue or concern that is unrelated to a denial of service. A complaint may involve clinical quality or administrative issues. Examples of possible issues for review are:

**Clinical Quality Issues:** Any actual, possible or potential adverse outcome in the member’s health status secondary to a physician or professional provider’s care or possible inappropriateness of a plan physician or professional provider’s behavior.

**Administrative Issues:** Denials of benefits, inability to maintain a satisfactory patient/physician or professional provider relationship, problems with BCBSTX’s staff or other contracted providers.

Physician or Professional Provider Satisfaction Survey
A series of questions asked of the Physician or other Professional Provider to measure satisfaction with BCBSTX’s services.

Post-service
A request for a service or procedure after the service or procedure has taken place.

Prior Authorization Request or Pre-Certification Request
A request for a service or procedure before the date the requested service or procedure is to occur.

Preventive Health Care
Health screenings, immunizations, and programs that help members prevent the development of certain diseases.

Primary Care Provider (PCP)
A pediatrician, general practitioner, family practitioner, internist, or sometimes an obstetrician/gynecologist or other provider who has contracted with us to provide primary care services to members and to refer, authorize, supervise and coordinate the provision of benefits to members in accordance with the member’s benefit agreement.

Primary Care Site
The PCP’s office or facility.

Protected Health Information (PHI)
Protected Health Information (PHI) under HIPAA includes any information about health status, provision of health care, or payment for health care that can be linked to an individual. It includes any part of a patient’s medical record or payment history.
Provider Manual
This Blue Cross and Blue Shield of Texas Provider Manual is a comprehensive document designed to inform managed care network providers of BCBSTX’s guidelines and requirements. The Provider Manual offers tools and information to assist providers in caring for our members.

Prudent Layperson
A person who possesses an average knowledge of health and medicine.

Quality Assessment and Performance Improvement (QAPI) Program
The QAPI is a written description of the quality program’s goals, objectives and structure. It details the role, function and reporting relationships of the Quality Improvement Committee (QIC) and the participation of practitioners and plan medical directors. This document serves as an outline of BCBSTX’s efforts to monitor and improve the quality of service and care to members.

Quality Specialists
A Quality Specialist is a CRC registered nurse who performs participating provider site reviews and medical record reviews and trains office staff on quality management techniques.

Receipt of Request
The date BCBSTX receives an appeal or complaint from a member or provider.

Re-Credentialing
Every three years the continuing participation of participating providers in BCBSTX’s managed care network is reviewed and re-evaluated.

Retrospective Review
A review of clinical information after the requested service has been rendered.

Routine Care
Health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

Self-Referral
Self-referral is the ability of a member to access a health care practitioner without having to see or be referred by anyone else first. A member may self-refer for special services that do not require prior authorization by us or the PCP.
Serious Chronic Condition
A medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.

Service Management
Administrative service performed by the MCO to facilitate development of a service plan and coordination of services among a member’s PCP, specialty providers and non-medical providers to ensure members with Special Health Care Needs have access to, and appropriately utilize, medically necessary covered services, non-capitated services, and other services and supports.

Skilled Nursing Facility (SNF)
A facility licensed to provide a level of inpatient nursing care that is not of the intensity required of a hospital.

Significant Traditional Provider
The Medicaid definition for a Significant Traditional Provider (STP) means primary care providers and long-term care providers, identified by Texas HHSC as having provided a significant level of care to fee-for-service clients. Disproportionate Share Hospitals (DSH) are also Medicaid STPs.

The CHIP definition for STP means primary care provider or professional providers participating in the CHIP HMO Program prior to May 2004, and Disproportionate Share Hospitals (DSH).

Specialist Physician or other Professional Provider
A plan physician who provides services to a member within the range of his or her designated specialty area of practice and who is specialty board certified or specialty board eligible in such specialty. Some specialty services do not require a referral; for example, obstetrical services.

Spell-of-Illness
The spell-of-illness limitation applies to clients in the STAR+PLUS program. A spell-of-illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

STAR or STAR Program
The State of Texas Access Reform, which means the State of Texas Medicaid Managed Care program in which HHSC contracts with HMOs to provide, arrange for and coordinate preventive, primary and acute care covered services to non-disabled children, families and pregnant women.
**State Fair Hearing**
An administrative hearing by the state for beneficiaries to resolve issues regarding benefits. All plan members have the right to access the Fair Hearing process at any time during the appeal process.

**Sterilization**
Any medical treatment, procedure or operation performed on a person (male or female) that permanently prevents the person from being able to reproduce.

**Temporary Assistance to Needy Families (TANF)**
Provides assistance and work opportunities to needy families by granting states the federal funds and wide flexibility to develop and implement their own welfare programs. Formerly known as Aid to Families with Dependent Children (AFDC).

**Texas Health Steps**
The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program. It includes the state’s Comprehensive Care program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. 1396d (r), and defined and codified at 42 C.F.R 440.40 and 441.56-62. HHSC’s rules are contained in 25 TAC, Chapter 243 (relating to Early and Periodic Screening, Diagnosis and Treatment Services).

**Universal Precautions**
The process of ‘universal blood and body precautions’ developed by the Centers for Disease Control and Prevention (CDC) to address concerns regarding transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C, and other blood-borne diseases. The concept assumes all patients are infectious for all blood borne diseases.

**Urgent Behavioral Health Situation**
A behavioral health condition that requires attention and assessment within 24 hours but which does not place the members in immediate danger to themselves or others; members are able to cooperate with treatment.

**Urgent Care**
Services needed to prevent serious deterioration of a member’s health resulting from unforeseen illness or injury for which treatment cannot be delayed.

**Urgent Condition**
A health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing an average knowledge of medicine, to believe that his or her condition requires medical evaluation or treatment within 24 hours by the member’s PCP or PCP designee to prevent serious deterioration of the member’s condition or health.
Urgent Examination
An examination performed by physician for a member with a non-life-threatening condition that could lead to a potentially harmful outcome, if not treated within 24 hours.

Utilization Management (UM)
The process of ascertaining that health care services are medically necessary, provided in the appropriate setting, and provided by the appropriate physician or professional provider.

Utilization Review
A function performed by an organization or entity acting as an agent of BCBSTX, and selected by BCBSTX, to review and approve whether health care services provided, or to be provided, are medically necessary.

Waste
Involves health care practices that are not cost-efficient.

Women, Infants, and Children (WIC) Program
A supplemental food and nutrition program for low income, pregnant, breastfeeding and postpartum women and children under age five who have a nutritional risk. WIC provides nutrition education, breastfeeding promotion, medical care referrals, and specific supplemental nutritious foods that are high in protein and/or iron. The specific nutritious foods provided to participants include peanut butter, beans, milk, cheese, eggs, iron-fortified cereal, iron-fortified infant formula and juices.

Working Day
Monday through Friday, excluding holidays and legal holidays observed by the Health and Human Services Commission.