Phase II CORE 260 Eligibility and Benefits (270/271) Data Content Rule Appendix §6.2 Glossary of Terms version 2.1.0 March 2011

Table of Contents

1 Introduction

For Phase I CORE, a common glossary of terms used within the context of the Phase I CORE Operating Rules was developed. The Phase II CORE 260 Eligibility and Benefits (270/271 Data Content Rule (hereafter Phase II Data Content Rule) involves a number of new terms that were not included in the Phase I CORE Operating Rule scope. It is beneficial to all CORE stakeholders to have a consistent understanding of these terms, especially since in some cases; similar but different wording is used to mean the same thing. In order to address this need for a Phase II CORE Operating Rules glossary an industry-wide research effort was conducted to obtain more detailed and authoritative information about terms and their usage as they apply to a health plan.

Compiling a list of commonly agreed-upon definitions for terms referenced in the Phase II Data Content Rule did present some challenges. No one single source was identified that could define the business terms that are being used in the Phase II Data Content Rule. CORE researched the use of terms and their definitions by nine organizations, including:

- Two BCBS plans
- Two commercial plans
- Medicare
- A Medicaid plan, and
- Two health plan associations
- ASC X12

Since these health plan documents define many of the data content terms and are used to describe the benefits in those terms to the individuals covered, these documents are a reliable source of information upon which to develop common definitions. As might be expected, not all of the organizations defined each term. Also, there was some variation found in the definitions used; and in some cases synonyms are used to mean the same thing. Differences in terminology such as, health plan beneficiary, health plan member, or health plan enrollee which refer to the same individual, reflect the varying roles a person may play in relation to benefit plan coverage administered by a given health plan.

The HIPAA-adopted ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) Technical Report Type 3 implementation guide and associated errata were found to often not have precise nor consistent definitions of the data elements and codes covered by them. For example, the definitions provided in the ASC X12 Standard for the 48 Service Type Codes included in the Phase II Data Content Rule that must be supported and included in response to an explicit v5010 270 eligibility request, either do not provide a definitive enough definition, or in many cases no definition at all, regarding these codes' intended usage. For these instances, CORE has included within the rule CORE supplemental descriptions *(see §4.1.1.1)* that provide clarification and meaning for codes, which the CORE participants agreed did not have a sufficiently clear or commonly understood definition provided in the HIPAA-adopted implementation guide. These ASC X12-related Service Type Codes are included in this Phase II CORE Glossary of Data Content Terms as well.

To support semantic interoperability for use in CORE, a single term identifier is being used and each term assigned a single definition. This glossary provides a compilation of these common terms identified as a result CORE's comparative analysis of terms used across eight of the nine sources reviewed. Where there was relative consistency, or only a single source had a definition for the term and it was a useful definition for CORE's purpose, that definition is the basis for the proposed CORE definition.[1] In those cases where a different definition was found in use, the CORE participants agreed upon the primary definition as included here.

2 Rules vs. Glossary Terms

The CORE terms and definitions do not replace a health plan's own terms used in their policies and contracts,

[1] The proposed terms and definitions are not in conflict with those used in the X12 Standards and Implementation Guides; rather they add specificity and clarity for use within CORE.

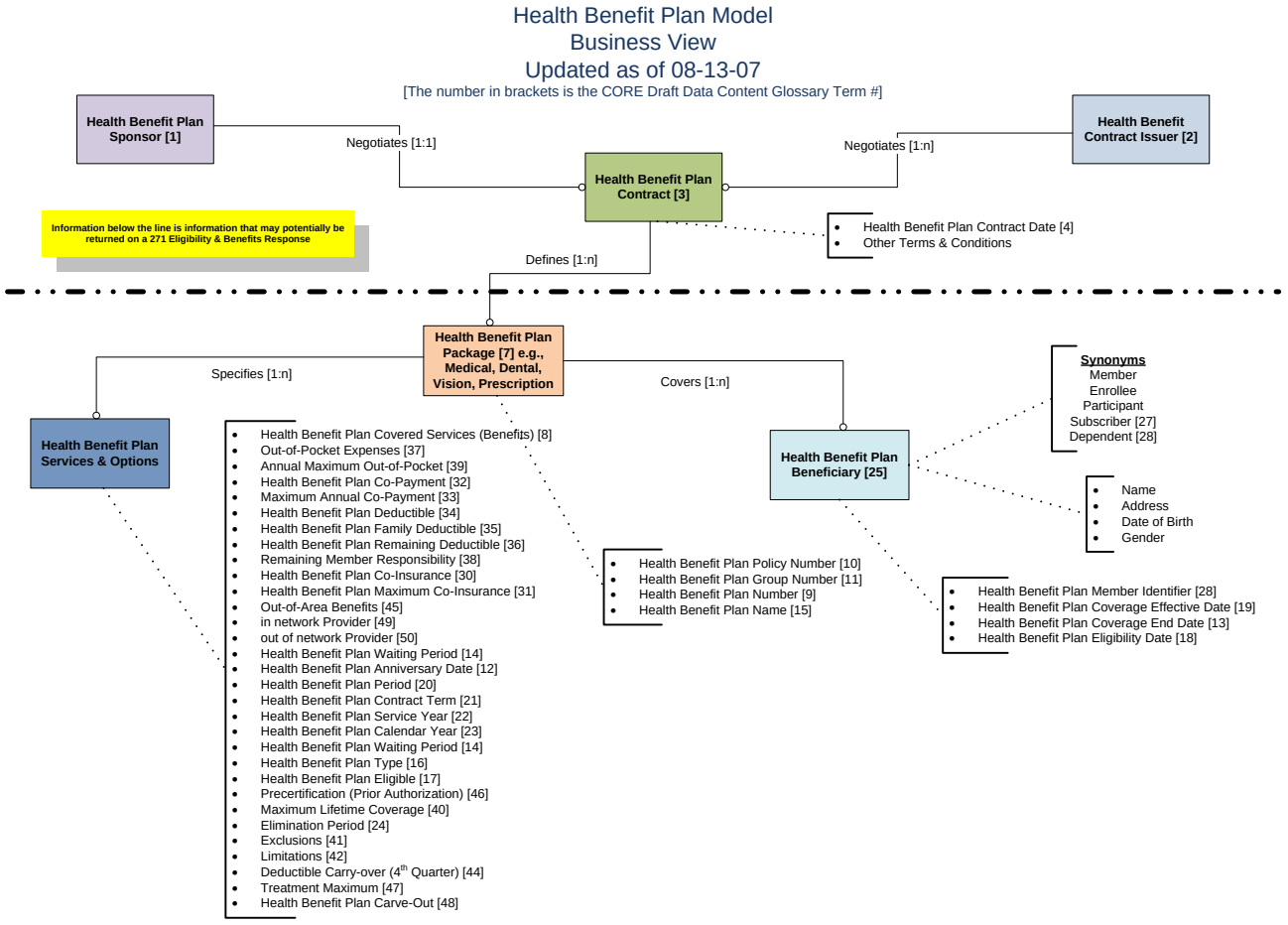
which may have legal implications, and which are the final authority for each plan's official definitions of terms and concepts specific to that plan. The Phase II CORE Glossary of Data Content Terms is for use solely within the context of the Phase II Data Content Rule and Phase II CORE Identifiers Rule in order to provide a common understanding and vocabulary for implementers of the CORE rules and CORE-certified stakeholders.

This said, a few terms are defined within the body of the Phase II Data Content Rule *(see §3.7 Abbreviations and Definitions Used in this Rule)* and, as such, are part of the rule. These definitions have also been included in this Phase II CORE Data Content Glossary of Terms.

Finally, a number of CORE Supplemental Descriptions *(See Table 4.1.1.1 of Phase II Data Content Rule)* have been added to provide additional clarity and meaning to ASC X12 Service Type Codes required in response to generic and explicit eligibility requests for Phase I and Phase II CORE rules. These supplemental descriptions are not part of the Phase II Data Content Rule, but have been added for guidance on the specific services included in each Service Type Code, and are also included in this glossary. Note: no CORE descriptions are provided for Service Type Codes where there was agreement among CORE participants that the ASC X12 Service Type Code definitions were sufficiently clear and commonly understood.

3 The Health Plan Business View Model (Conceptual)

The graphical model below is a generalized model of a typical health plan. It does not represent any organization's specific health plan. This conceptual model of a health plan depicts the key terms and concepts used in various Phase II CORE Operating Rules using business language rather than ASC X12 technical specifications and definitions. It is not intended to replace any definitions or descriptions used in any ASC X12 transaction set or implementation guide, but rather to provide a common language and vocabulary for implementers of the Phase II CORE Operating Rules and CORE-certified stakeholders.



4 CORE Data Content Glossary:

Term #	CORE Term	CORE Definition
1	Annual Out-of-Pocket Maximum	Dollar amount set by the health plan that limits the amount a beneficiary (member) has to pay out of their own pocket for particular covered healthcare services during a specified time period, sometime referred to as "stop loss".
2	Approved [Allowed] Amount [Charge]	The maximum fee Medicare will pay in a given area for a covered benefit [service]
3	Deductible Carry-over (4th quarter)	A provision in a health plan that allows the beneficiary (member) who has not satisfied his/her deductible in a given benefit period to apply expenses incurred in the last quarter of that benefit period to the next benefit period's deductible.
4	Elimination Period	The number of days in which a beneficiary (member) receives covered care or services before benefits are payable.
5	Exclusions	Specific conditions or circumstances specified in the health plan contract that are not covered under the health benefit agreement.
6	Health Plan Coverage Effective Date	Date on which a beneficiary's (member's) coverage begins, typically occurring at the end of an eligibility waiting period stipulated by the health plan sponsor.
7	Health Plan Anniversary Date	The month and day that a health plan first goes into effect is the anniversary date each year.
8	Health Plan Beneficiary Or Health Plan Member Or Health Plan Enrollee	A person who is eligible to receive benefits under a health benefits plan. Sometimes "beneficiary" is used for eligible dependents enrolled under a health plan. "Beneficiary" can also be used to mean any person eligible for benefits, including both employees and eligible dependents.
9	Health Plan Calendar Year	The duration of the member's specific coverage with the health plan defined as January 1 through December 31 of the same year.[2]
10	Health Plan Carve-out	Certain services (benefits) or a group of services (benefits) that are administered by a specialist third party vendor. Services separately designed and contracted to an exclusive, independent provider by a managed care plan.[3]
11	Health Plan Co-insurance	A cost-sharing requirement that the beneficiary (member) pay a designated portion of eligible services after the deductible is met; usually designed as a percentage of the allowed amount for the covered service.
12	Health Plan Contract	A legal agreement between an individual subscriber, an employer group or a health plan sponsor and a health benefit contract issuer that describes the benefits and limitations of the coverage.
13	Health Plan Contract Date	The effective date of the health plan contract.
14	Health Plan Contract Issuer	An insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a group health plan.[4]
15	Health Plan Contract Term	The duration of the member's specific coverage with the health plan.[5]
16	Health Plan Co-payment	A cost-sharing requirement that the beneficiary (member) pay a specified flat dollar amount for a specified service.

[2] Ibid

[3] State of Washington Office of Insurance Commissioner Insurance Glossary of Insurance Terms www.insurance.wa.gov

[4] Defined in section 2791(b)(2) of the PHS Act, 42 U.S.C. 300gg-91(b)(2) and included in HIPAA Administration Simplification statute by reference.

[5] Definition adapted from the BCBS Association definition

Term #	CORE Term	CORE Definition
17	Health Plan Coverage End [Termination/Expiration] Date	The date on which health plan coverage ends (terminates) for a beneficiary (member).
18	Health Plan Covered Services [Benefits]	The benefits that are provided according to the terms of a beneficiary's (member's) specific health plan package.
19	Health Plan Deductible	The dollar amount of covered services based on the allowed benefit that must be paid by an individual or family per benefit period before the health plan begins to pay its portion of claims. The benefit period may be a specific date range of one year or other as specified in the plan.
20	Health Plan Dependent	A person eligible for coverage under a health plan because of that person's relationship to the subscriber; spouses, children and adopted children are often eligible for dependent coverage. As defined in §1.4.2 of the HIPAA-adopted ASC X12 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3, a dependent is a person who cannot be uniquely identified to an information source (by a member identifier), but can be identified when associated with a subscriber.
21	Health Plan Eligibility Date	The defined date a covered person becomes eligible for benefits under an existing health plan contract.
22	Health Plan Eligible [Eligibility]	Provisions contained in each health plan that specify who qualifies for coverage under that plan.
23	Health Plan Family Deductible	The amount of annual deductible required to be paid when there are two or more family members on the health plan policy. Many policies limit the annual family deductible to some multiple (e.g., two times) of the individual deductible.
24	Health Plan Group Number	A number assigned to the health plan group policy by the health plan issuer.
25	Health Plan Member Identifier	The unique identifier associated with a beneficiary (member).
26	Health Plan Name	A name assigned to a given health plan by the health plan issuer to "brand" or otherwise describe the product.
27	Health Plan Number	An identifier assigned to the health plan by the health plan issuer, or assigned by HHS.
28	Health Plan Package	Services an insurer, government agency, health plan, or an employer offers to a beneficiary under the terms of a contract.
29	Health Plan Patient Liability [Responsibility]	Portion of submitted charges that is beneficiary's (member's) responsibility. Amount may include deductible, co-insurance, co-payment, amounts over annual out-of-pocket maximum, or amounts for services or products not covered by the health plan.
30	Health Plan Period	The maximum length of time specified in a health plan during which covered services or benefits are eligible for payment.
31	Health Plan Policy Number	A number assigned to the health plan policy by the health plan issuer.
32	Health Plan Policyholder	The entity that has the contract or agreement with the health plan contract issuer. Under a group plan, the group is the policyholder; under an individual plan, the individual is the policyholder.
33	Health Plan Remaining Deductible	The portion of either the individual or family deductible amount that is the beneficiary's (member's) financial responsibility yet to be paid.
34	Health Plan Service Year	The duration of the member's specific coverage with the health plan defined as a 365-day (366 in leap year) contractual period. This period may not necessarily be a calendar year (for example, April 1 through May 31).[6]

[6] Ibid.

Term #	CORE Term	CORE Definition
35	Health Plan Sponsor	The employer in the case of an employee benefit plan established or maintained by a single employer; the employee organization in the case of a plan established or maintained by an employee organization; or in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.[7]
36	Health Plan Subscriber	An individual, meeting the health plan's eligibility requirement, who enrolls in the health plan and accepts the financial responsibility, if any, for any premiums, co-payments, co-insurance, or deductibles. As defined in §1.4.2 of the HIPAA-adopted ASC X12 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3, a subscriber is a person who can be identified to an information source by a unique Member Identification Number.
37	Health Plan Type	A form of health plan with operational differences that distinguishes it from another form of health plan. The five health plan types found in the United States are:[8] : • Preferred Provider Organizations (PPOs); • Health Maintenance Organizations (HMOs); • Consumer Directed Health (CDH) Plans; • Point-of-Service (POS) Offerings • Indemnity Coverage • Other
38	Health Plan Waiting Period [Eligibility Period]	A period of time an individual must wait either to become eligible for health plan coverage or to become eligible for a given benefit after overall coverage has commenced.
39	In-Network Provider [Supplier]	A healthcare provider such as a physician, skilled nursing facility, home health agency, laboratory, DME supplier, etc., that has an agreement with the health plan contract issuer to provide covered services to members. Also referred to as a "contract" or "participating" provider.
40	Limitations	Specific circumstances or services listed in the health plan contract for which benefits will be limited.
41	Maximum Annual Co-payment	The limit on the amount of money a beneficiary (member) spends in co-payments in a health plan period for covered in-network expenses.
42	Maximum Annual Health Plan Co-Insurance	The limit on the amount of money a beneficiary (member) spends on out-of-pocket costs for co-insurance on covered services during a health plan benefit period.
43	Maximum Lifetime Coverage	The maximum amount the health plan will pay in benefits for each beneficiary (member) during their lifetime.
44	Out-of-Area Benefits	Benefits the health plan provides to covered persons for covered services obtained outside of the network service area.
45	Out-of-Network Provider [Supplier]	A healthcare provider such as a physician, skilled nursing facility, home health agency, laboratory, etc., that does not have an agreement with the health plan contract issuer to provide covered services to members. Also referred to as a "non-contract" or "non-participating" provider.

[7] Employee Retirement Income Security Act – ERISA – 29 U.S. Code Chapter 18 and included in HIPAA Administrative Simplification by reference

[8] http://www.urac.org/resources/healthPlanDescription.aspx

Term #	CORE Term	CORE Definition
46	Out-of-pocket Expenses	The share of health services payments paid by the beneficiary (member).
47	Precertification [Prior Authorization]	A process to review and assess the medical necessity and appropriateness of elective hospital admissions and non-emergency outpatient services before the services are provided.
48	Remaining Member Responsibility	Portion of submitted charges that is the beneficiary's (member's) responsibility after payments from the underlying health plan, Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) or HealthCare Flexible Spending Account (FSA).
49	Stop Loss [Stop Loss Insurance]	The practice of a health plan protecting itself or its participating providers against part of or all losses above a specified dollar amount incurred in the process of caring for its beneficiaries (members). Usually involves the health plan or insurance company purchasing insurance from another company to protect itself. Also referred to as reinsurance.
50	Treatment Maximum	Maximum number of treatments or visits for certain conditions.

5 Additional Data Content Terms included in and part of the Phase II Rule:

Term #	CORE Term	CORE Definition
51	Benefit-specific Base Deductible	The dollar amount of a specific covered service based on the allowed benefit that is separate and distinct from the Health Plan Base Deductible that must be paid by an individual or family before the health plan begins to pay its portion of claims. The specific benefit period may be a specific date, date range, or otherwise as specified in the plan.
52	CORE Supplemental Descriptions	CORE supplemental descriptions (clarification/meaning) are for guidance until definitive clarified definitions can be obtained within the ASC X12 standards. They provide a general understanding of the specific services which are included in each service type, but the description may not be all inclusive. No CORE description is provided for Service Type Codes where there was agreement among the CORE participants that the X12 Standard Code Definition is sufficiently clear and commonly understood.
53	Explicit Inquiry	An Explicit Inquiry is a 270 Health Care Eligibility Benefit Inquiry that contains a Service Type Code other than and not including "30" (Health Benefit Plan Coverage) in the EQ01 segment of the transaction. An Explicit Inquiry asks about coverage of a specific type of benefit, for example, "78" (Chemotherapy). See §3.7).
54	Generic Inquiry	In contrast to an Explicit Inquiry, a Generic Inquiry is a 270 Health Care Eligibility Benefit Inquiry that contains only Service Type Code "30" (Health Benefit Plan Coverage) in the EQ01 segment of the transaction. See §3.7.
55	Health Plan Base Deductible	The dollar amount of covered services based on the allowed benefit that must be paid by an individual or family per benefit period before the health plan begins to pay its portion of claims. The benefit period may be a specific date range of one year or other as specified in the plan. (See the entry for Deductible in the Phase II CORE Glossary of Health Plan Terms.)
56	Health Plan Coverage Date for Individual	The effective date of health plan coverage actually in operation and in force for the individual.
57	Support [Supported] Service Type	Support [or Supported] means that the health plan (or information source) must have the capability to receive a 270 inquiry for a specific Service Type Code and to respond in the corresponding 271 response in accordance with this rule.

6 Phase I and Phase II CORE Eligibility and Benefits (270/271) Data Content Supplemental Descriptions

See Table 4.1.1.1 of Phase II CORE 260 Eligibility and Benefits (270/271) Data Content Rule

In Phase I Data Content Rule & Glossary		
Term #	**CORE Term**	**CORE Definition**
58	Chiropractic	Professional services which may include office visits, manipulations, lab, x-rays, and supplies.
59	Dental Care	Benefits for services, supplies or appliances for care of teeth.
60	Emergency Services	Medical services and supplies provided by physicians, Hospitals, and other healthcare professionals for the treatment of a sudden and unexpected medical condition or injury which requires immediate medical attention.
61	Hospital Inpatient	Hospital services and supplies for a patient who has been admitted to a hospital for the purpose of receiving medical care or other health services.
62	Hospital Outpatient	Hospital services and supplies for a patient who has not been admitted to a hospital for the purpose of receiving medical care or other health services.
63	Medical Care	Medical care services to diagnose and/or treat medical condition, illness or injury. Medical services and supplies provided by physicians and other health care professionals.
64	Pharmacy	Drugs and supplies dispensed by a licensed Pharmacist, which may include mail order or internet dispensary.
65	Professional (Physician) Visit-Office	Professional services of a Physician or other Health Care Professional during an office visit.
66	Vision	Routine vision services furnished by an optometrist. May include coverage for eyeglasses, contact lenses, routine eye exams, and/or vision testing for the prescribing or fitting of eyeglasses or contact lenses.
In Phase II Data Content Rule		
67	Ambulatory Service Center Facility	A freestanding facility that provides services on an outpatient basis, primarily for the purpose of performing medical, surgical or renal dialysis procedures.
68	Durable Medical Equipment Purchase	Purchase of medically necessary equipment and supplies prescribed by a physician or other healthcare provider that can withstand repeated use, is medically necessary for the patient, is not useful if the patient is not ill or injured, and can be used in the home.
69	Durable Medical Equipment Rental	Rental of medically necessary equipment and supplies prescribed by a physician or other healthcare provider that can withstand repeated use, is medically necessary for the patient, is not useful if the patient is not ill or injured, and can be used in the home.
70	Hospital - Emergency Accident	Hospital services and supplies for the treatment of a sudden and unexpected injury that requires immediate medical attention.
71	Hospital - Emergency Medical	Hospital services and supplies for the treatment of a sudden and unexpected condition that requires immediate medical attention.
72	Professional (Physician) Visit - Inpatient	Professional services of a physician during an inpatient hospital admission.
73	Skilled Nursing Care	Services and supplies for a patient who has been admitted to a skilled nursing facility for the purpose of receiving medical care or other health services.
74	Surgical Assistance	Assistant Surgeon/surgical assistance provided by a physician if required because of the complexity of the surgical procedures.

