CLARITI GLOSSARY AND TERMINOLOGY

Accreditation	An evaluative process in which a healthcare organization undergoes an examination of its operating procedures to determine whether they meet designated criteria and to ensure that the organization meets a specified level of quality.
Actual Charge	The amount that a physician or other practitioner charges for a particular medical service or procedure. The actual charge may differ from the allowed charges.
Adjudication	The process that health plans use to determine the amount of payment to a provider for a claim for services.
Administrative services contract (ASC)	The contract between an employer and a third-party administrator; also referred to as an ASO.
American National Standards Institute (ANSI)	A national organization founded to develop voluntary business standards in the United States.
Authorization	A health plan's system of giving advance approval for a patient to receive services to ensure that the services satisfy the plan's requirements for coverage.
Bundling	Including multiple covered services into a single charge, rather than individual line items. Typically this is agreed upon in advance between the payor and provider organizations.
Benefit	Amount payable by the insurance company to a patient or provider when a claim is submitted. Benefits are specific areas of Plan coverage's, i.e., outpatient visits, hospitalization and so forth, that makes up the range of medical services that a payer markets to its subscribers.
Beneficiary Liability	The amount beneficiaries must pay providers for covered services. Liabilities include copayments, coinsurance, deductibles, and balance billing amounts.
CAHPS	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their health care experiences. Surveys cover topics important to consumers and focus on those aspects of quality that consumers are best qualified to assess.
Carve-out services	Specialty health services that a managed care organization obtains for members by contracting with a company that specializes in that service. See also carve-out vendors. Carve-out refers to an arrangement where some benefits (e.g., behavioral health) are removed from coverage provided by an insurance plan, but are provided through a contract with a separate set of providers.
Claim	An itemized statement of healthcare services and their costs provided to a patient by a hospital, physician's office, or other provider facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment

	of the costs incurred.
Coordination of benefits (COB)	A verification system that health insurers use to ensure a claim is not paid in duplicate when the patient has more than one type of coverage.
Co-Insurance	Co-insurance refers to money that an individual is required to pay for services, after a deductible has been paid. In some health care plans, co-insurance is called "co-payment." Co-insurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.
Co-Payment	Co-payment is a predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, some HMOs require a $10 "co-payment" for each office visit, regardless of the type or level of services provided during the visit. Co-payments are not usually specified by percentages.
Deductible	The amount an individual must pay for health care expenses before insurance (or a self-insured company) covers the costs of covered services. Often, insurance plans are based on yearly deductible amounts.
Eligibility	The electronic connection with a payor, typically via a clearinghouse, to confirm a member's current insurance coverage and out of pocket expenses.
Exclusions	Medical services that are not covered by an individual's insurance policy. Also known as non-covered or non-allowed items.
Experience Survey	An experience survey is a set of questions designed to gauge the overall satisfaction of patients and family who have shared a common provider experience. Survey results may be used to drive an improvement program and compare results with similar providers. CMS and other bodies may require providers to conduct experience surveys, such as CAHPS surveying.
Explanation of benefits (EOB)	A summary sent to members to explain payments made by the insurance company on the member's behalf.
Fee schedule	The list of standard fees for all procedures and services, also known as the chargemaster. In Clariti, each line item in the fee schedule must be classified as a facility fee, professional fee, implant, bundle, anesthesia or other.
Hold	The ability to put a patient estimate on hold pending further research or information gathering. A hold can be automatically released.
Implant	An implantable device deployed during surgery and implanted within a patient.
Individual Stop-loss	A type of insurance that provides benefits for claims on an individual who exceeds a stated amount in a given period.
In-Network	Providers or health care facilities which are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.

Insured	A person, including dependents, covered by an insurance contract; also known as a covered person or member.
Lifetime Maximum	The maximum dollar amount set by a managed care organization that the plan must pay for covered healthcare services provided to a subscriber in the subscriber's lifetime.
Member	An eligible individual who is enrolled in an insurance plan. A member may be a subscriber or a dependent of the subscriber.
National Provider Identifier (NPI)	The standard unique health identifier healthcare providers will have to use in filing and processing electronic healthcare claims and other transactions starting May 23, 2007 as required by HIPAA.
Network Provider	A medical provider who has contracted with a health plan to provide services to its members.
Never Send	The ability to prevent a specific patient from ever receiving an estimate.
Non-participating provider	A medical provider who has not contracted with a particular health plan to provide services to its members.
Out-of-Pocket Maximum	An out-of-pocket maximum is the most you'll have to pay during a policy period (usually a year) for health care services. Once you've reached your out-of-pocket maximum, your plan begins to pay 100 percent of the allowed amount for covered services.
Participating Provider	An individual physician, hospital, or professional healthcare provider who has a contract with a health plan to provide services to its members.
Patient Reported Outcome	A PRO is a measurement based on a report that comes from the patient about the status of a patient's health condition in the voice of the patient. A PRO can be measured by self-report or by interview, provided that the interviewer not interpret or modify the patient's responses. Symptoms or other unobservable concepts known only to the patient (e.g., pain severity or mobility) can only be measured by PRO measures. PROs can also assess the patient perspective on functioning or activities that may also be observable by others.
Pay-for-Performance Programs	Programs that pay providers an incentive for delivering quality care to our members.
Payor Contract	A contract a provider signs with a healthcare insurer to become a participating provider. Also known as the agreement.
Plan allowance	The maximum dollar amount a contract allows for services covered, regardless of the provider's actual charge. Also referred to as allowed amount or allowable charge.
Pre-authorization	Approval necessary for designated procedures or hospital admissions. When care is received in-network, the PCP or specialist is usually responsible for obtaining pre-authorization. For out-of-network services, the member is responsible for obtaining

	pre-authorization. Also referred to as pre-certification.
Pre-certification	See pre-authorization.
Self-insured Account	An employer that designs and funds its own health plan for its employees, usually based on a local managed care network and claims system. The employer assumes financial risk and only pays the managed care organization administrative fees to process claims and handle service. Also known as self-funded.
Usual, Customary and Reasonable (UCR)	The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the amount of money they will approve for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, if an individual questions his or her physician about the fee, the provider will reduce the charge to the amount that the insurance company has defined as reasonable and customary.
X12 270/271	An inquiry (270) to the patient's health insurance company to obtain current coverage information and to see if a patient has valid health insurance coverage. (271) is the response or return file from the carrier or medical claims clearing house to the inquiry.
X12 276/277	An inquiry to obtain information regarding an 837 submitted to a payer to get the status of a particular claim. (277) is the response or return file data to the inquiry.
X12 835/837	An 837 is a claim submitted to an insurance carrier for payment for a patient visit. (835) is the explanation of benefits and an amount of payment paid to a facility or physician in response to a claim.