

## Section 12 – Glossary

Term	Definition
<b>Accreditation Association for Ambulatory Health Care (AAAHC)</b>	Accreditation Association for Ambulatory Health Care (AAAHC) is a private, non-profit organization formed in 1979. They are the leader in developing standards to advance and promote patient safety, quality care, and value for ambulatory health care through peer-based accreditation processes, education, and research.
<b>Advisory Committee on Immunization Practices (ACIP)</b>	ACIP is chartered as a federal advisory committee to provide expert external advice and guidance to the Director of the Centers for Disease Control and Prevention (CDC) on use of vaccines and related agents for the control of vaccine-preventable diseases in the civilian population of the United States. Recommendations for routine use of vaccines in children and adolescents are harmonized to the greatest extent possible with recommendations made by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Obstetrics and Gynecology (ACOG). Recommendations for routine use of vaccines in adults are reviewed and approved by the American College of Physicians (ACP), AAFP, ACOG, and the American College of Nurse-Midwives. ACIP recommendations adopted by the CDC Director become agency guidelines on the date published in the Morbidity and Mortality Weekly Report (MMWR).
<b>Affordable Care Act (ACA) or Health Reform, Public Law 111-148</b>	The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA – is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will “continue to be rolled out over the next four years.” Key provisions are intended to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions.
<b>Allowed Amount</b> See also <b>UCR</b>	Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)
<b>American Academy of Family Physicians (AAFP)</b>	AAFP's website has an area called Running a Practice that has good information on billing and coding. <a href="http://www.aafp.org/online/en/home/practicemgt.html">http://www.aafp.org/online/en/home/practicemgt.html</a>
<b>American Academy of Pediatrics (AAP)</b>	AAP website has a helpful page regarding immunizations [ <a href="http://www2.aap.org/immunization/">http://www2.aap.org/immunization/</a> ] and more useful information on coding and billing and fee development on their Practice Support page [ <a href="http://www.aap.org/en-us/professional-resources/practice-support/Pages/Practice-Support.aspx">http://www.aap.org/en-us/professional-resources/practice-support/Pages/Practice-Support.aspx</a> ]
<b>Appeal</b>	A request for your health insurer or plan to review a decision or a grievance again.
<b>Assigned Claims</b>	Participating providers must and non-participating providers can submit and receive payment on assigned claims. When a provider submits an assigned claim, the provider agrees to accept the Medicare allowance as payment in full for the submitted charges. A provider cannot bill the patient for more than the 20% copayment, any amounts applied to the Medicare deductible and any non-covered services. The provider could bill the beneficiary in situations where the service is statutorily excluded from coverage or when the beneficiary has signed a written Advance Beneficiary Notice prior to receiving a service when this service is expected to be denied because it is not medically necessary or reasonable.
<b>Association of Health Insurance Plans (AHIP)</b>	AHIP is the national trade association representing the health insurance industry. AHIP provided multiple webinars for the Billables Project.  There is also a Wisconsin chapter at: <a href="http://www.wihealthplans.org/">http://www.wihealthplans.org/</a>

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<b>Balance Billing</b>	When a provider bills the patient for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100, and the allowed amount is \$70, the provider may bill for the remaining \$30. A preferred provider may not balance bill for covered services.
<b>Benefit</b>	The amount payable by the insurance company to a claimant, assignee, or beneficiary when the insured suffers a loss.
<b>Black Lung Disease</b>	If the patient has black lung disease, Medicare will not pay when treatment is covered by the federal Black Lung Program, which is run by the Department of Labor (DOL). If DOL has said that the patient is not eligible for Black Lung Program benefits, Medicare will pay as primary. Medicare should pay for any service that is not related to the Black Lung Disease Program. If the patient is being treated for black lung, then the claim information should be sent to: Federal Black Lung Program P.O. Box 8302 London, KY 40742-8302 1-800-638-7072
<b>Bronze plan</b>	A Bronze health plan – available through state health insurance exchanges created by the ACA – covers 60 percent of the cost of essential benefits, while the patient pays 40 percent – up to an out-of-pocket maximum of roughly \$6,000 for an individual or \$12,000 for a family (2013).
<b>Carrier</b> also known as <b>Insurance Company; Payer, Insurer, Health Plan</b>	The insurance company or HMO offering a health plan.
<b>Carrier/ Medicare Administrative Contractor (MAC)</b>	Medicare contractors that reimburse covered physician and supplier services rendered in various places, such as a doctor's office, hospital, patient's home, nursing home, etc. Medicare Contracting Reform (MCR) Update - Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) enacted numerous contracting reforms. A key aspect of these reforms is that Medicare will begin integrating Fiscal Intermediaries (FIs) and Carriers into a new single authority, called a Medicare Administrative Contractor (MAC). As of October 1, 2005, new Medicare Contractors are called MACs. Also, from October 2004 through October 2011, all existing FI and Carrier contracts will be transitioned into MAC contracts, using competitive procedures. Providers may access the most current MCR information to determine the impact of these changes at <a href="http://www.cms.hhs.gov/MedicareContractingReform/">http://www.cms.hhs.gov/MedicareContractingReform/</a> on the CMS website.
<b>Centers for Disease Control and Prevention</b>	CDC funded this toolkit through a grant from the Prevention and Public Health Fund (PPHF) [ <a href="http://www.cdc.gov/vaccines/spec-grps/prog-mgrs/billables-project/default.htm">http://www.cdc.gov/vaccines/spec-grps/prog-mgrs/billables-project/default.htm</a> ]
<b>Centers for Medicare and Medicaid Services (CMS)</b>	Agency that provides oversight of the Medicare and Medicaid programs. Funding for VFC program is allocated through this agency. CMS website is located at: <a href="http://cms.hhs.gov/">http://cms.hhs.gov/</a>
<b>ChampVA</b>	In 1973, the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) was established as a health benefits program for dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions, or who at the time of death, were rated permanently and totally disabled from a service-connected condition. Under CHAMPVA, VA shares the cost of covered medical services and supplies with eligible beneficiaries worldwide.

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<p><b>Children's Health Insurance Program (CHIP),</b> formerly known as <b>State Children's Health Insurance Program (SCHIP)</b></p>	<p>The Children's Health Insurance Program (CHIP), formerly the State Children's Health Insurance Program (SCHIP), was created by the Balanced Budget Act of 1997, enacted Title XXI of the Social Security Act, and has allocated about \$20 billion over 10 years to help states insure low-income children who are ineligible for Medicaid but cannot afford private insurance or their family income is below 200 percent of the federal poverty line. States receive an enhanced federal match (greater than the state's Medicaid match) to provide for this coverage. Affordable Care extended the authorization of the federal CHIP program for an additional two years, through September 30, 2015. If state runs out of federal funding, children can be enrolled in comparable Exchange plans.</p> <p>Within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. States can implement CHIP in one of three methods.</p> <p><b>Medicaid Expansion</b> - A state increases the income limits so more children are eligible for Medicaid. These children (since they are enrolled in Medicaid) are VFC-eligible.</p> <p><b>Separate CHIP</b> - A state develops a new health insurance plan/program that may have different rules and benefits than the state Medicaid plan. Children enrolled in a separate CHIP program are NOT considered VFC-eligible because they are insured by this new plan or program.</p> <p><b>Combination Plan</b> - A state implements CHIP through a Medicaid expansion, where the state increases the income limits so more children are eligible for Medicaid. These children (since they are enrolled in Medicaid) are VFC-eligible. The state also develops a separate CHIP plan, which is a new health insurance plan/program that may have different rules and benefits than the state Medicaid plan. Children enrolled in a separate CHIP program are NOT considered VFC-eligible because they are insured by this new plan or program.</p>
<p><b>Claim</b></p>	<p>A claim is an application for benefits provided by your health plan. You must file a claim before funds will be reimbursed to your medical provider. A claim may be denied based on the carrier's assessment of the circumstance.</p>
<p><b>CMS Form 1500 (08/05)</b></p>	<p>CMS Form 1500 (08/05) is the standard paper claim form that all providers use when filing their paper claims with Medicare Part B. The paper form comes printed in red ink and has CMS 1500 (08/05) printed on the bottom right corner. Effective July 2, 2007, the HCFA 1500 form became obsolete and will not be accepted, even for adjustment claims.</p>
<p><b>COBRA plan/policy</b></p>	<p>The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 is a federal legislation that allows an employee/dependent – if they worked for an insured employer group of 20 or more employees – to continue to purchase health insurance for up to 18 months after job loss or when employer-sponsored coverage is otherwise terminated.</p>
<p><b>Co-insurance</b></p>	<p>The 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 “copayment.” Coinsurance 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.</p>
<p><b>Comprehensive Clinic Assessment Software Application (CoCASA)</b></p>	<p>A tool for assessing immunization coverage levels, VFC/AFIX activities and provider compliance with high-priority VFC compliance questions within a clinic, private practice, or any other setting where immunizations are provided. This software has data entry and import capabilities and can generate a number of reports, two of which can be used to complete the VFC Management Survey.</p>

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<b>Coordination of Benefits Agreement (COBA) with CMS' Coordination of Benefits Contractor (COBC)</b>	The Centers for Medicare & Medicaid Services (CMS) has established a centralized Coordination of Benefits (COB) operation by consolidating under a single contractor entity, the Coordination of Benefits Contractor (COBC), the performance of all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries. The CMS has a centralized COB operation that provides quality customer service to Medicare providers, suppliers and beneficiaries by streamlining the payment process while ensuring the integrity of the Medicare Trust Funds. To further that goal, CMS requires the COBC to maintain a comprehensive health care insurance profile on all Medicare beneficiaries and carry out other activities necessary to meet these objectives. The COBC telephone number is 1-800-999-1118.
<b>Co-payment</b>	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 copayment for each office visit, regardless of the type or level of services provided during the visit. Copayments are not usually specified by percentages
<b>Cost Sharing</b>	The share of costs covered by the insured and the insurance company, also called out-of-pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.
<b>Council for Affordable Quality Healthcare (CAQH)</b>	A nonprofit alliance of health plans and trade associations. Its two main initiatives are the Committee on Operating Rules for Information Exchange (CORE) and Universal Provider Datasource (UPD). CAQH aims to reduce administrative burden for providers and health plans. See <b>UPD</b>
<b>Deductible</b>	The amount an individual and/or family must pay for health care expenses before insurance (or a self-insured company) covers the costs. Often, insurance plans are based on yearly deductible amounts.
<b>Delegated Authority</b>	A formal agreement, generally through a Memorandum of Understanding, whereby Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) delegate their VFC authority for vaccinating underinsured children to other VFC-enrolled providers, usually public health department clinics, who then vaccinate underinsured children as agents of the FQHC/RHC.
<b>Denial of a claim</b>	The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional.
<b>Department of Health and Human Services, Office of Inspector General (OIG)</b>	Office mandated to protect the integrity of Department of Health and Human Services (HHS) programs and their beneficiaries. It is generally responsible for identifying, communicating and correcting activities of waste, fraud or abuse within HHS programs.
<b>Dependent</b>	A person or persons relying on the policy holder for support may include the spouse and/or unmarried children (whether natural, adopted or step) of an insured.
<b>Detailed Signature Requirements</b>	<p>The patient's signature <b>authorizes release of medical information</b> necessary to process the claim. It <b>authorizes payment of benefits to the provider</b> when he/she accepts assignment on the claim.</p> <p>If the patient is physically or mentally unable to sign, a representative may sign on behalf of the patient. A representative payee, legal representative, relative, friend, representative of an institution providing the patient care or support, or a representative of a governmental agency assisting the patient may sign the claim.</p> <p>In this case, the statement signature line must indicate the patient's name followed by "BY" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.</p>

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<b>Diagnosis</b>	Identification of a condition, disease, disorder, or problem by systematic analysis of the background or history, examination of the signs or symptoms, evaluation of the research or test results, and investigation of the assumed or probable causes.
<b>Diagnosis code</b>	<p>Standardized code values assigned to a diagnosis. The codes are developed by the World Health Organization and published in the International Classification of Diseases (ICD).</p> <p>The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 was used to code and classify mortality data from death certificates until 1999, when use of ICD-10 for mortality coding started. The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services are the U.S. governmental agencies responsible for overseeing all changes and modifications to the ICD-9-CM.</p> <p>Effective October 1, 2014, ICD-10-CM will become the official standard for the US.</p>
<b>Diagnosis Pointer</b>	<p>When multiple services are performed in a single encounter, certain services may be related to certain diagnoses, while other services are associated with different diagnoses.</p> <p>On the CMS-1500 claim form, box 24E (Diagnosis Pointer) is used to indicate which diagnosis is related to each specific service billed. If multiple services are performed, providers should enter the diagnosis reference number in box 24E to relate each service to the appropriate diagnosis in box 21.</p> <ul style="list-style-type: none"> <li>• Reference numbers entered in box 24E must be 1, 2, 3 or 4, and a valid diagnosis code is required in the corresponding field in box 21.</li> <li>• Do not enter ICD-9 codes in box 24E. Those codes should be entered in box 21.</li> <li>• Up to four reference numbers can be entered for each service.</li> </ul>
<b>Disabled and Covered by a Large Group Health Plan (LGHP)</b>	If the patient is disabled and is covered by a Large Group Health Plan (100 or more employees) because he or she is working or is covered by a LGHP of a working family member, then Medicare is the secondary payer.
<b>Effective Date</b>	The date your insurance coverage commences. Sometimes used to denote the first date of service or the beginning of a provider's participation, or any other beginning date.
<b>Electronic equivalent (X12N 837P)</b>	The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837P implementation guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. The implementation guides for each X12 transaction adopted as a HIPAA standard are available electronically at the <a href="http://www.wpc-edi.com">http://www.wpc-edi.com</a> website. CMS provides a companion guide, which supplements, but does not contradict any requirements in the X12N 837P Professional Implementation Guide. This companion guide is available through your local Medicare contractor.
<b>Electronic Health Record (EHR)</b>	A long-term aggregate of a patient's health information and may be a record of a variety of providers and types of medical care. This record is <b>sometimes confused with an <u>electronic medical record</u></b> , which is a record of a patient's health maintained by a physician as a record primarily of the physician's care of the patient.
<b>Electronic Medical Record (EMR)</b>	A record of patient health maintained by the patient's physician as a record of that physician's care of the patient. This record is <b>often confused with an <u>electronic health record</u></b> , which is a more comprehensive, long-term aggregate of a patient's health information and may be a record of a variety of providers and types of medical care.

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<b>Employer Sponsored Health Plan or Group Health Plan (GHP)</b>	Of Americans who have health coverage, nearly 60 percent secure that coverage through an employer-sponsored plan, often called group health insurance. Millions take advantage of the coverage for reasons as obvious as employer responsibility for a significant portion of the health care expenses. Group health plans are also guaranteed issue, meaning that a carrier must cover all applicants whose employment qualifies them for coverage. In addition, employer-sponsored plans typically are able to include a range of plan options from HMO and PPO plans to additional coverage such as dental, life, short- and long-term disability.
<b>End Stage Renal Disease (ESRD) and Covered by a Group Health Plan (GHP)</b>	If a patient is under 65 and has Medicare coverage solely on the basis of ESRD, and has GHP coverage, the GHP is the primary payer for the first 30 months of Medicare eligibility or entitlement.
<b>Essential Health Benefits</b>	Beginning in 2014, under the Affordable Care Act, all health insurance policies sold in state health insurance exchanges must cover what physicians and consumer advocates call essential health benefits. The benefits include: 1. Ambulatory patient services; 2. Emergency services; 3. Hospitalization; 4. Maternity and newborn care; 5. Mental health and substance use disorder services, including behavioral health treatment; 6. Prescription drugs; 7. Rehabilitative and habilitative services and devices; 8. Laboratory services; 9. <b>Preventive</b> and wellness services and chronic disease management; 10. Pediatric services, including oral and vision care. <i>Preventive care includes immunizations.</i>
<b>Exclusion</b>	Is a provision within a health insurance policy that eliminates coverage for certain acts, property, types of damage or locations.
<b>Exclusive Provider Organization (EPO)</b>	A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan’s network (except in an emergency). Similar to a PPO, but with a more limited provider panel.
<b>Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB)</b>	An explanation of benefits is the insurance company’s written explanation regarding a claim, showing what they paid and what the client must pay. The document is sometimes accompanied by a benefits check. Medicare has their own format of the same type of document.
<b>Family Planning Clinic</b>	Clinic or provider whose main purpose is to prescribe contraceptives. This does not include school-based clinics or any VFC-enrolled provider whose main services are primary or acute care services.
<b>Federal Poverty Level (FPL)</b>	This level is set by the government and varies based on family size (so the federal poverty level for an individual is a lower dollar amount than the federal poverty level for a family of four). Individuals with incomes below the poverty level are believed to be lacking the resources to meet their basic needs.
<b>Federal Register</b>	The Federal Register is the official daily publication for rules, proposed rules, and notices of Federal agencies and organizations, as well as executive orders and other presidential documents. On October 3, 1994, the Federal Register published the notice that set forth the interim maximum amounts a participating provider may charge for administering a VFC vaccine to a VFC-eligible child. The interim amounts are still in place today.

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<b>Federally Qualified Health Center (FQHC)</b>	Health center that is designated by the Bureau of Primary Health Care (BPHC) of the Health Services and Resources Administration (HRSA) to provide health care to a medically underserved population. FQHCs include community and migrant health centers, special health facilities such as those for the homeless and persons with acquired immunodeficiency syndrome (AIDS) that receive grants under the Public Health Service (PHS) Act, as well as "look-alikes," which meet the qualifications but do not actually receive grant funds. They also include health centers within public housing and Indian Health Service centers.
<b>Federally Vaccine-eligible Child</b> Also known as VFC-eligible Child	Child who is eligible to receive VFC vaccine.
<b>Fee Schedule</b>	A list of maximum dollar allowances for health care procedures that apply under a specific contract - usually tied to a specific CPT or HCPCS code.
<b>Fee-for-service</b>	A system of health insurance payment in which a doctor or other health care provider is paid a fee for each particular service rendered.
<b>Grandfathered Plan</b>	<p>As used in connection with the Affordable Care Act: A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010).</p> <p>A grandfathered health plan isn’t required to comply with some of the consumer protections of the Affordable Care Act that apply to other health plans that are not grandfathered.</p>
<b>Health Insurance Exchange</b>	<p>A federal Web site that will allow consumers to: (1) check their eligibility for government assistance programs, including any subsidies available to help pay for private health insurance; (2) compare health insurance plans based on cost and quality; and (3) link consumers to insurers for the purchase of health insurance after they choose a plan they are interested in.</p> <p>The federal government has recently attempted to change the name from Health Insurance Exchanges to “Health Insurance Marketplaces.” However, in an effort to limit confusion between the federal Exchange Web site and the private insurance marketplace, this document and <b>Wisconsin will use the term “Exchange.”</b></p>
<b>Health Insurance Portability and Accountability Act of 1996 (HIPAA)</b>	A federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also creates the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health information.

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<p><b>Health maintenance organization (HMO)</b> Also known as <b>Managed Care Plan</b></p>	<p>A comprehensive health care financing and delivery organization that provides or arranges for provision of covered health care services to a specified group of enrollees, at a fixed periodic payment, through a panel of providers. Historically, four types of HMO models have been common:</p> <p><b>Staff or closed model:</b> Physicians are salaried employees of the HMO. Group Health Cooperative of South Central Wisconsin is considered a staff model HMO.</p> <p><b>Group model:</b> HMO contracts with providers through multi-specialty physician group practices. Dean Health Plan is considered a for-profit, group-model HMO.</p> <p><b>IPA model:</b> HMO contracts with Independent Practice Associations (IPA), which, in turn, contract with independent physicians who practice in their own office. Humana of Wisconsin is considered an IPA model HMO.</p> <p><b>Network model:</b> HMO contracts with two or more independent group practices and/or IPAs. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital medical plans. Physician's Plus is considered a network model HMO.</p>
<p><b>Healthcare Effectiveness Data and Information Set (HEDIS)</b></p>	<p>A standardized set of performance measures that assesses plans' performance on a number of elements, including such things as access, quality of care, and financial stability. HEDIS enables purchasers and consumers to compare the performance of managed care plans. It is sponsored by the National Committee for Quality Assurance (NCQA). Immunizations provided by a LHD can count toward the health plan's score, if immunizations are included in that year's criteria.</p>
<p><b>Herd Immunity</b> Also known as <b>Community Immunity</b></p>	<p>The principle of herd immunity is when a large percentage of the population is vaccinated, the spread of disease is limited. This indirectly protects unimmunized individuals, including those who can't be vaccinated and those for whom vaccination was not successful.</p> <p>In diseases spread from person to person, it is more difficult to maintain a chain of infection when much of the population is vaccinated. As the number of those vaccinated increases, the protective effect of herd immunity increases. For some diseases, herd immunity may begin when as little as 40 percent of the population is vaccinated. More commonly, and depending on the contagiousness of the disease, vaccination rates may need to be as high as 80-95 percent. This percentage is called the herd immunity threshold.</p>
<p><b>Inactivated Vaccine</b></p>	<p>A vaccine made from viruses and bacteria that have been killed through physical or chemical processes. These killed organisms cannot cause disease.</p>
<p><b>Indemnity Health Insurance</b></p>	<p>These plans are also called "fee-for-service." These are the types of plans that primarily existed before the rise of HMOs, IPAs, and PPOs. With indemnity plans, the individual pays a pre-determined percentage of the cost of health care services, and the insurance company (or self-insured employer) pays the rest. For example, an individual might pay 20 percent for services and the insurance company pays 80 percent. The fees for services are defined by the providers and vary from physician to physician. Indemnity health plans offer individuals the freedom to choose their health care professionals.</p>

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<b>Indian (American Indian or Alaska Native)</b>	<p>As defined by the Indian Health Care Improvement Act (25 U.S.C. 1603):  “Indians” or “Indian”, unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) of this section, except that, for the purpose of sections 1612 and 1613 of this title, such terms shall mean any individual who</p> <p>(1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or</p> <p>(2) is an Eskimo or Aleut or other Alaska Native, or</p> <p>(3) is considered by the Secretary of the Interior to be an Indian for any purpose, or</p> <p>(4) is determined to be an Indian under regulations promulgated by the Secretary.</p> <p><i>(d) “Indian tribe” means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.</i></p>
<b>Individual Health Insurance</b>	Health insurance coverage on an individual, not group, basis. The premium is usually higher for an individual health insurance plan than for a group policy, but you may not qualify for a group plan.
<b>In-network</b> Also known as <b>In-Plan, Participating or Par Provider or Preferred Provider</b>	Refers to providers or health care facilities that 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. <b>Under the Affordable Care Act, cost-sharing is waived for immunizations only if the provider is an "in-network" provider.</b>
<b>Insurance</b>	<p>An plan/policy of health benefits that is::</p> <ul style="list-style-type: none"> <li>• Regulated by a State’s Insurance Commissioner, and/or</li> <li>• Subject to the Employee Retirement Income Security Act of 1974 (ERISA).</li> </ul> <p>ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.</p> <p>Under the ACA, beginning January 1, 2014, individuals of all ages must have health insurance or pay a penalty of \$95, or 1% of income, whichever is greater. Individuals will report to the IRS in 2015 whether they had health insurance coverage in 2014 and therefore pay the \$95 penalty in 2015 (if they did not have coverage). Information on exemptions is available at:  <a href="http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision">http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision</a></p>
<b>Liability Insurance</b>	<p>Liability insurance covers people when they are legally responsible for someone else's injuries or property damages. Malpractice insurance can fall into this category.</p> <p>Liability insurance is primary to Medicare. A physician who treats a Medicare patient who has filed a liability claim must bill the liability insurance first unless the insurance will not pay during the 120-day promptly period. After the 120-day promptly period, the physician may either continue the lien or claim against the liability insurance or bill Medicare. If the physician bills Medicare, he/she must drop any liens and claims against the liability insurance.</p>

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<b>Limiting charge</b>	<p>The limiting charge is the maximum amount that most non-participating providers are allowed to charge for services to a Medicare beneficiary on an unassigned basis. The limiting charge does not apply to participating providers, non-participating providers when assignment is accepted, and some non-physician practitioner specialties that are required to bill on an assigned basis.</p> <p>The limiting charge amount for most physician fee schedule services are listed under the WPS Medicare Fees web page. This constitutes "notice" of the Medicare charge limits for those services.</p> <p>The limiting charge is 115% of the Medicare allowed amount for services performed by nonparticipating physicians, i.e., 95% of the fee schedule for participating physicians. If the service is reduced in processing to accommodate provisions of the Medicare law, the limiting charge is 115% of the reduced allowed amount.</p> <p>Services that are not separately payable are also subject to limiting charge. The charge for the service is the amount of the limiting charge violation.</p> <p>The submission of a non-assigned physician fee schedule service with a charge in excess of the Medicare limiting charge amount constitutes a violation of the limiting charge. A provider who violates the limiting charge is subject to assessments of up to \$10,000 per violation plus triple the amount of the charges in violation, and possible exclusion from the Medicare program.</p>
<b>Live Vaccine</b> Also known as <b>Attenuated Vaccine</b>	A vaccine in which live virus is weakened through chemical or physical processes in order to produce an immune response without causing the severe effects of the disease. Examples of attenuated vaccines currently licensed in the United States include measles, mumps, rubella, shingles (herpes zoster), varicella, yellow fever and nasally administered influenza vaccine. Also known as a live vaccine.
<b>Maximum Limit</b>	The maximum amount of money, or number of visits, that an insurance company (or self-insured company) will pay for claims within a specific time period. Maximum limits vary greatly. They may be based on or specified in terms of types of illnesses or types of services. Sometimes they are specified in terms of lifetime, sometimes for a year.
<b>Maximum Regional Charge</b>	The amount that a VFC-enrolled provider can charge a non-Medicaid VFC-eligible child for each vaccine administered (also known as the administration fee or “admin fee”). State Medicaid agencies have the authority to reimburse at a lower level. The Centers for Medicare and Medicaid Services (CMS) has the responsibility of setting and adjusting the maximum regional charges. See Federal Register.
<b>Medicaid</b>	For patients over 65 who are receiving Medicaid, physicians must accept assignment. State Medicaid programs are required to pay the copayments and deductibles of "qualified Medicare beneficiaries" (QMB). Generally, state welfare agencies give Medicaid a list of Medicare-eligible people on welfare, including their Medicare ID numbers. Medicare is always primary for patients that have Medicaid.
<b>Medicaid</b> Also known as <b>Title XIX</b>	Federal and state partnership that creates a medical assistance plan for poor and disabled Americans. It is sometimes called Title XIX because it was authorized under Title XIX of the Social Security Act. VFC is part of the larger Medicaid program, but has different eligibility criteria than the Medicaid assistance plan for both providers and participants.
<b>Medicaid-eligible Child</b>	A child who is eligible for the Medicaid Program. For the purposes of the VFC program, the terms “Medicaid-eligible” and “Medicaid-enrolled” are equivalent and refer to children who have health insurance coverage by a state Medicaid program.
<b>Medicare Advantage Plan</b>	A federal program providing Medicare coverage through the private insurance market. These plans have a special arrangement between the federal Centers for Medicare & Medicaid Services (CMS) and certain insurance companies. Medicare Advantage plans that are HMOs or preferred provider plans have a "lock in" requirement which means that, except for emergency or urgent care situations away from home, the enrollee must receive all services, including Medicare services, from plan providers.

## Section 12 – Glossary

Term	Definition
<b>Medicare Part B or Supplemental Medical Insurance</b>	<p>Part B covers 2 types of services:</p> <p>Medically necessary services: Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.</p> <p>Preventive services: Health care to prevent illness (like influenza) or detect it at an early stage, when treatment is most likely to work best. The following vaccines are covered under Part B:</p> <ol style="list-style-type: none"> <li>a. Influenza – vaccine and administration covered once per flu season without coinsurance, copayment or Medicare Part B deductible if provider accepts assignment</li> <li>b. Pneumococcal – vaccine and administration covered once per lifetime [Medicare will also cover a booster vaccine for high risk persons if 5 years have passed since the last vaccination.]</li> <li>c. Hepatitis B - covers vaccine and administration for intermediate- to high-risk individuals without deductible or coinsurance cost-sharing.</li> <li>d. Other Vaccines when directly related to the treatment of an injury or direct exposure to a disease or condition (e.g., Tetanus (Td) – for wound management only)</li> </ol> <p><a href="http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0727.pdf">http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0727.pdf</a></p>
<b>Medicare Part D or Prescription Drug Plan</b>	<p>A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.</p> <p>Part D pays for immunizations not covered under Part B, such as the vaccine for shingles.  <a href="http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0727.pdf">[http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0727.pdf]</a></p>
<b>Medicare</b> Also known as <b>Original Medicare or Parts A &amp; B</b>	<p>The federal health insurance program created to provide health coverage for Americans aged 65 and older and later expanded to cover younger people who have permanent disabilities or who have been diagnosed with end-stage renal disease or amyotrophic lateral sclerosis (ALS). Original Medicare was, and is, a fee-for-service coverage under which the government pays health care providers directly for Part A and/or Part B benefits.</p> <p>Medicare will not pay for medical services covered by Workers' Compensation, the state-supervised insurance system for job related injuries and diseases. If your patient has a disease or injury incurred on the job, the claim must be filed with Workers' Compensation (WC) first. If any of the following are true, Medicare may be billed for the service.</p> <ol style="list-style-type: none"> <li>1. The job related medical problem isn't covered by WC</li> <li>2. The condition develops on the job, but is not work related</li> <li>3. The patient has used up all WC benefits (send documentation)</li> <li>4. A condition not related to work exists with a condition covered by WC (send documentation).</li> </ol> <p>Veterans who are entitled to Medicare may choose which program will be responsible for payment for services covered by both programs. Medicare cannot pay for the same service that was authorized by the VA or performed by a VA facility.</p>
<b>Medigap Insurance</b>	<p>Medigap plans offer supplemental benefits sold by private companies to extend traditional Medicare. Fifteen plans offer varying combinations of benefits, ranging from coverage of copayments and deductibles to coverage of foreign travel emergency expenses, at-home care and preventive care. In most, the benefit is derived from this benefit logic "if Medicare doesn't pay, this policy doesn't pay."</p>
<b>Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP)</b>	<p>MMCAP is a no-cost, voluntary group purchasing organization, operated by the State of Minnesota since 1985, for government facilities that provide healthcare services. Members receive access to a full range of pharmaceuticals and other healthcare products and services; such as, medical supplies, influenza and other vaccines, dental supplies, drug testing, wholesaler invoice auditing and returned goods processing.</p>

## Section 12 – Glossary

Term	Definition
<b>National Association of County and City Health Officials (NACCHO)</b>	The NACCHO website has a free, online collection of local public health tools produced by members of the public health community. Tools within the Toolbox are materials and resources public health professionals and other external stakeholders can use to inform and improve their work in the promotion and advancement of public health objectives. Current examples of tools include, but are not limited to case examples, presentations, fact sheets, drills, evaluations, protocols, templates, reports, and training materials. Billing toolkit information is located at: <a href="http://www.naccho.org/toolbox/index.cfm?v=4&amp;id=243&amp;topicname=Billing">http://www.naccho.org/toolbox/index.cfm?v=4&amp;id=243&amp;topicname=Billing</a>
<b>National Committee for Quality Assurance (NCQA),</b>	The National Committee for Quality Assurance (NCQA) is a 501(c)(3), non-profit organization that manages voluntary accreditation programs for individual physicians, health plans, and medical groups. Health plans seek accreditation measure performance through the administration and submission of the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.
<b>National Provider Identifier (NPI)</b>	The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated that the Secretary of the Department of Health and Human Services adopt a standard unique identifier for health care providers called the National Provider Identifier (NPI). All HIPAA covered entities (which are health plans, health care clearinghouses, and those health care providers who conduct standard transactions) must accept and use NPIs in standard transactions by May 23, 2007 (small health plans had until May 23, 2008). Effective May 23, 2008, covered health care providers will use only their NPIs to identify themselves in standard transactions where a health care provider identifier is required. These transactions include claims, eligibility inquiries and responses, referrals, and remittance advices. The NPI replaced health care provider identifiers that were being used in standard transactions and eliminated the need to use different identification numbers when conducting HIPAA standard transactions with multiple plans. Providers can apply for a National Provider Identifier using one of the following methods: Call (800) 465-3203 to request a paper application; or Submit an application in an electronic file, visit <a href="https://nppes.cms.hhs.gov/">https://nppes.cms.hhs.gov/</a> on the CMS website and complete the web-based application.  The CMS website has a dedicated webpage on NPI for all health care providers. Visit <a href="http://www.cms.hhs.gov/NationalProvIdentStand/">http://www.cms.hhs.gov/NationalProvIdentStand/</a> on the CMS website. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation.
<b>Non-Assigned Claims</b>	Only non-participating providers can submit non-assigned claims (they can also submit assigned claims). Medicare will submit payment for non-assigned claims to the beneficiary or his/her established legal representative. The beneficiary cannot be billed for more than the established limiting charge for most services performed by a physician. Providers should contact their local contractor for a list of services that may apply to the limiting charge.
<b>Nurse, Nurse Practitioner, Advance Practice Nurse or PractitionerRN, NP, ANP</b>	WI statute 441.001(2) Nurse. Except as provided under s. 441.08, "nurse," when used without modification or amplification, means only a registered nurse. WI Statute 441.16 (2) The board shall grant a certificate to issue prescription orders to an advanced practice nurse who meets the education, training and examination requirements established by the board for a certificate to issue prescription orders, and who pays the fee specified under s. 440.05 (1).
<b>Ordering physician</b>	A physician, or non-physician practitioner, when appropriate who orders non-physician services for the patient.
<b>Ordering Provider</b>	The ordering provider is the individual who requested the services or items listed in Block D of the CMS-1500 paper claim form. Examples include, but are not limited to, a provider ordering diagnostic tests, medical equipment, or supplies.
<b>Other Purchase Policy</b>	Any purchase policy not described above, such as the combination of two or more of the above policies.

## Section 12 – Glossary

Term	Definition
<b>Out-of-Network</b> Also known as <b>Out-of-Plan, Non-Participating or Non-Par Provider or Non-Preferred Provider</b>	This phrase usually refers to physicians, hospitals or other health care providers who are considered nonparticipants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company. Immunizations given by these providers are subject to deductibles, co-insurance or co-payments under Affordable Care Act.
<b>Out-of-Pocket Maximum</b>	A predetermined limited amount of money that an individual, or family, must pay out of their own savings, before an insurance company or (self-insured employer) will pay 100 percent for an individual's health care expenses.
<b>Physician Assistant (PA)</b>	WI statute 488.01 (6) "Physician assistant" means an individual licensed by the medical examining board to provide medical care with physician supervision and direction.
<b>Physician MD, DO</b>	WI statute 488.01 (5) "Physician" means an individual possessing the degree of doctor of medicine or doctor of osteopathy or an equivalent degree as determined by the medical examining board, and holding a license granted by the medical examining board.
<b>Point of Service Plan (POS)</b>	A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans may require you to get a referral from your primary care doctor in order to see a specialist.
<b>Preferred Provider Organization (PPO)</b>	Is a managed care organization of health providers who contract with an insurer or third-party administrator (TPA) to provide health insurance coverage to policy holders represented by the insurer or TPA. Policy holders receive substantial discounts from health care providers who are partnered with the PPO. If policy holders use a physician outside the PPO plan, they typically pay more for the medical care.
<b>Primary Source Verification</b>	A process through which a health plan validates credentialing information from the organization that originally conferred or issued the credentialing element to the practitioner (e.g., a medical license is verified with the licensing board).
<b>Private Health Insurance Marketplace</b>	This refers to the Wisconsin health insurance market offering health insurance plans outside of the Exchange.
<b>Provider</b>	A term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals such as hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services. See also Physician, Physician Assistant, and Nurse Practitioner.
<b>Provider Enrollment, Chain and Ownership System (PECOS)</b>	Internet-based PECOS is an electronic Medicare enrollment system through which providers and suppliers can: <ul style="list-style-type: none"> <li>• Submit Medicare enrollment applications;</li> <li>• View and print enrollment information;</li> <li>• Update enrollment information;</li> <li>• Complete the revalidation process;</li> <li>• Voluntarily withdraw from the Medicare Program; and</li> <li>• Track the status of a submitted Medicare enrollment application.</li> </ul>
<b>Provider Network</b>	A group of doctors, hospitals and other health care providers contracted to provide services to insurance companies' customers for less than their usual fees. Provider networks can cover a large geographic market or a wide range of health care services. Insured individuals typically pay less for using a network provider.

## Section 12 – Glossary

Term	Definition
<b>Providers and services that can only be paid on an assignment basis</b>	<p>Clinical diagnostic laboratory services;            Physician services to individuals dually entitled to Medicare and Medicaid;            Participating physician/supplier services;            Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;            Ambulatory surgery centers for covered ASC procedures;            Home dialysis supplies and equipment paid under Method II;            Ambulance services;            Drugs and biological;            Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.</p>
<b>Public Health Accreditation Board (PHAB)</b>	<p>Administers the national public health department accreditation program for public health departments operated by Tribes, states, local jurisdictions and territories. Began LHD accreditation in 2013. Accreditation includes 12 domains: (1) Conduct and disseminate assessments focused on population health status and public health issues facing the community, (2) Investigate health problems and environmental public health hazards to protect the community, (3) Inform and educate about public health issues and function, (4) Engage with the community to identify and address health problems, (5) Develop public health policies and plans, (6) Enforce Public Health Laws, (7) Promote strategies to improve access to health care services (8) Maintain a competent public health workforce, (9) Evaluate and continuously improve health department processes, programs and interventions, (10) Contribute to and apply the evidence base of public health, (11) Maintain administrative and management capacity, (12) Maintain capacity to engage the public health governing entity. West Allis Public Health Department is the first WI LHD to receive this accreditation.</p>
<b>Purchased Service Provider</b>	<p>A purchased service provider is an individual or entity that performs a service on a contractual or reassignment basis.            Examples of services include the following:</p> <ul style="list-style-type: none"> <li>• Processing a laboratory specimen</li> <li>• Grinding eyeglass lenses to the specifications of the referring provider</li> <li>• Performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule</li> </ul> <p>In the case where a substitute provider is used, that individual is not considered a purchased service provider.</p>
<b>Reasonable and Customary</b> See also <b>Allowed Amount</b>	<p>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.</p>
<b>Referring physician</b>	<p>The referring provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form.            Examples include, but are not limited to the following:</p> <ul style="list-style-type: none"> <li>• A primary care provider referring to a specialist</li> <li>• An orthodontist referring to an oral and maxillofacial surgeon</li> <li>• A physician referring to a physical therapist</li> <li>• A provider referring to a home health agency</li> </ul>
<b>Registry for Effectively Communicating Immunization Needs (RECIN)</b>  <b>formerly: Regional Early Childhood Immunization</b>	<p>An immunization registry that is accessible to immunization providers (public and private), schools and daycares throughout Wisconsin. RECIN allows providers to track immunizations across the lifespan of their patients. RECIN provides an accurate, up-to-date record of all vaccinations a patient has received. The Marshfield Clinic deployed RECIN in 1994, to assist immunization providers in central and northern Wisconsin to meet the Healthy People 2000 goal – 90 percent of children with immunizations up-to-date by age two. It serves a 23-county area.</p> <p>Approximately 10 health departments submit data to RECIN, which is then submitted to the Wisconsin Immunization Registry (WIR).</p>

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Term	Definition
<b>Registry</b>	
<b>Rendering Provider</b>	The rendering provider is the individual who provided the care to the patient. In the case where a substitute provider was used, that individual is considered the rendering provider. An individual such as a lab technician or radiology technician who performs services in a support role is not considered a rendering provider.
<b>Rural Health Clinic (RHC)</b>	An RHC is a clinic located in a Health Professional Shortage Area, a Medically Underserved Area, or a Governor-Designated Shortage Area. RHCs are required to be staffed by physician assistants, nurse practitioners, or certified nurse midwives at least half of the time that the clinic is open.
<b>Section 317 Funds</b>	Discretionary federal grant funds to 64 state and local grantees provided through an annual federal appropriation. Section 317 funds provide a safety net to provide vaccines to underinsured children and adolescents not served by the VFC program, and, as funding permits, provide vaccines to uninsured and underinsured adults. Grantees prioritize their Section 317 funds to meet the needs of their priority populations using public or private vaccination settings. Under the Section 317 program, states and grantees have broad discretion as to which ages, life stages, high-risk groups, or diseases will be targeted. Although the VFC program is the primary source of federal vaccine purchase funding for pediatric and adolescent vaccines, the vast majority of operations support for state immunization programs comes from the Section 317 immunization grant funds.
<b>Self-Insured Plan</b>	Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.
<b>State Funds</b>	State-contributed funds used to purchase vaccine for children who are not VFC-eligible or to support program operations.
<b>State Vaccine-eligible Child</b>	Child who is eligible to receive vaccine that was purchased with 317/state funds, usually off the federal CDC contract.
<b>Supervising Provider</b>	The supervising provider is the individual who provided oversight of the rendering provider and the services listed on the CMS-1500 paper claim form. An example would be the supervision of a resident physician.
<b>TRICARE and TRICARE for Life</b>	Tricare is the health care program for active duty and retired uniformed services members and their families.  Tricare for Life is expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses. Medicare is generally primary to TRICARE. However, if a patient receives services from a military hospital or other federal provider, TRICARE will pay because Medicare will not pay for services received from a federal provider or other federal agency.
<b>Uncompensated Care</b>	Health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.
<b>Underinsured Child</b>	A child who has insurance, but the coverage does not include vaccines, a child whose insurance covers only selected vaccines or a child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured. Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center or Rural Health Clinic. In Wisconsin, underinsured children are also eligible to receive state-supplied vaccine at local health departments.
<b>Uninsured Child</b>	A child who has no health insurance coverage.

## Section 12 – Glossary

Term	Definition
<b>Universal Provider Datasource (UPD)</b>	The CAQH Universal Provider Datasource (UPD) allows registered physicians and other health professionals in all 50 states and the District of Columbia to enter their information free of charge into a single, uniform online application that meets the data needs of health plans, hospitals and other healthcare organizations. Approximately 7,000 new providers begin using the service each month. The provider data-collection service streamlines the initial application and re-credentialing processes, reduces provider administrative burdens and costs, and offers health plans and networks real-time access to reliable provider information for claims processing, quality assurance and member services, such as directories and referrals. UPD is supported by the American Medical Association, the American Academy of Family Physicians; the American College of Physicians, the Medical Group Management Association; America’s Health Insurance Plans, the American Health Information Management Association, and other provider organizations. Indiana, Kansas, Kentucky, Louisiana, Maryland, Missouri, New Jersey, New Mexico, Ohio, Rhode Island, Tennessee, Vermont and the District of Columbia have adopted the CAQH Standard Provider Application as their mandated or designated provider credentialing form. The UPD form meets all related URAC, National Committee on Quality Assurance and the Joint Commission on Accreditation of Healthcare Operations standards.
<b>URAC</b>	Formerly known as the Utilization Review Accreditation Commission, is a nonprofit organization promoting healthcare quality by accrediting healthcare organizations. URAC accredits many types of health care organizations, depending on the functions they carry out. There are a number of different accreditation programs, some that review the entire organization, such as the health plan standards, and some that focus on quality within a single functional area in an organization, e.g. case management or credentialing. Any organization that meets the standards, including hospitals, HMOs, PPOs, TPAs and provider groups can seek accreditation.
<b>Usual, Reasonable and Customary (UCR)</b> Also known as <b>Allowed Amount</b>	An amount customarily charged for or covered for similar services and supplies which are medically necessary, recommended by a doctor, or required for treatment.
<b>Vaccine Funding Source</b>	How grantees use the three (VFC, 317, and state/local) funding sources to purchase vaccines. <ul style="list-style-type: none"> <li>· VFC funds: Federal entitlement funds used to purchase vaccines for administration to VFC-eligible children;</li> <li>· 317 funds: Federal discretionary funds that can be used to purchase vaccine for non-VFC eligible populations;</li> <li>· State funds: State contributed funds used to purchase vaccines for individuals who are not VFC-eligible.</li> </ul>
<b>Vaccine Purchase Policy</b> Also known as <b>Vaccine Supply Policy</b>	Policy that determines what vaccines a grantee will purchase, what funding sources will be used and what populations will be eligible to receive the vaccine.
<b>Veterans Health Administration</b>	VA operates the nation's largest integrated health care system, with more than 1,700 hospitals, clinics, community living centers, domiciliaries, readjustment counseling centers, and other facilities.  Veterans with private health insurance may choose to use these sources of coverage as a supplement to their VA benefits. It is important to note that VA health care is NOT considered a health insurance plan.  By law, VA is obligated to bill health insurance carriers for services provided to treat a Veteran’s non-service-connected conditions. Veterans are asked to cooperate by disclosing all relevant health insurance information. Eligible Veterans are not responsible for payment of VA medical services billed to their health insurance company that are not paid by their insurance carrier.

## Section 12 – Glossary

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Term	Definition
<b>VFC Funds</b>	The Office of Management and Budget approves funding for the VFC program. Funding is through the Centers for Medicare and Medicaid Services to the CDC with awards made to 61 eligible grantees. Funding is used to purchase vaccines only for VFC-eligible children. Grantees receive VFC funding to support VFC-related activities, such as vaccine ordering and VFC/AFIX site visits.
<b>VFC-eligible Child</b> Also known as <b>Federally Vaccine-eligible Child</b>	Child who is 18 years of age or younger and meets one or more of the following categories: is an American Indian or Alaska Native; or is eligible/enrolled in Medicaid; or has no health insurance; or is underinsured (and receives vaccine through a FQHC or RHC; or an LHD in WI).
<b>Workers' Compensation (WC)</b>	Insurance that employers are required to have to cover employees who get sick or injured on the job

