UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
AARP - American Association of Retired Persons (Note: AARP is preferred terminology)	AARP (formerly known as the American Association of Retired Persons) serves enrollees, age 50 and over, and focuses its efforts and resources in four areas: health and wellness, economic security and work, long-term care and independent living, and personal enrichment.
ACM - Ancillary Care Management	A home health care management company with a variety of web-based solutions; ACM has been engaged by the APM unit to help develop and manage home infusion and other specialty care networks; link: http://www.acmcentral.com/ACM/homepage.asp
ACN - American Chiropractic Network or ACN Group	A wholly owned subsidiary of UnitedHealth Group's Specialized Care Services business segment and a national leader in providing network-based chiropractic and complementary and alternative medicine services including low-back, soft-tissue, and joint rehabilitation solutions. ACN corporations include Managed Physical Network, Inc., Managed Physical Network IPA of New York, Inc. and American Chiropractic Network IPA of New York, Inc. link: http://www.acngroup.com
AHIP and AAHP-HIAA Insurance Education	AHIP (America's Health Insurance Plans) is a national trade association based in Washington, D.C. representing nearly 1,300 member companies providing health benefits to more than 200 million Americans. AAHP-HIAA's (American Association of Health Plans-Health Insurance Association of American) Insurance Education program offers current, comprehensive and economically priced self-study courses for professionals seeking to advance their understanding of the health insurance industry.
Alternative Medicine	Therapeutic interventions that typically place the healing power of nature first, and technique and technology second.
AMT - Account Management Team	An Account Management Team (AMT) consists of representatives from all functional areas responsible for new business implementation, maintenance and renewal, who meet on a regular basis to address customer issues.
APM - Ancillary Program Management	The unit within UnitedHealth Networks responsible for strategy, program design and implementation, performance management associated with ancillary services (i.e. Lab, Radiology, Ambulatory Surgery, Home Health, DME, Dialysis, Specialty Pharmacy, etc.); web link: http://uhn.uhc.com/NatlAncillary/index.htm
APT – Admissions Per Thousand	The number of hospital admissions per 1,000 health plan members. The formula for this measure is: (# of admissions/member months) x 1000 members x # of months
ARO (Audit and Recovery Operations)	Primary function of ARO is to identify and pursue the recovery of overpaid claims for fully insured business (commercial, Ovations, AmeriChoice, etc.) – *previously referred to as RAR (Regional Audit and Recovery).*
ASO - Administrative Services Only	Management services provided by a third party for an employer group that is financially at risk for the cost of health care services. Management services may include claim payments, care coordination services, and/or network access. This is a common arrangement when a employer sponsors a self-funded health benefit program.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
CAQH – Council for Affordable Quality Healthcare	The Council for Affordable Quality Healthcare (CAQH) is a not-for-profit alliance of the nation's leading health plans and networks that promotes collaborative initiatives to help make healthcare more affordable, share knowledge to improve the quality of care, and make administration easier for physicians and their patients..
Choice	UnitedHealthcare Choice provides all the benefits of an HMO while allowing enrollees to see network specialists without a referral. Benefits are only available through our network of physicians and other health care professionals.
Choice Plus	UnitedHealthcare Choice Plus provides all the benefits of an HMO while allowing enrolled individuals to see network specialists without a referral. UnitedHealthcare Choice Plus also has an "opt-out" feature that lets enrollees see out-of-network physicians and other health care professionals, but generally at a lower coinsurance level.
CMC - Care Management Centers	Care Management Centers (CMC) is the collective name given to the service centers that provide medical management services to enrollees and their dependents.
CME - Comprehensive Medical Expense	Comprehensive Medical Expense (CME) is a plan type that includes deductibles and out-of-pocket maximums, and covers broad types of services up to a lifetime maximum. Services are subject to reasonable and customary or negotiated rates.
CMS - Centers for Medicare & Medicaid Services (Note: formerly the Health Care Financing Administration – HCFA; spell out first reference, CMS is fine on second reference)	Centers for Medicare & Medicaid Services (CMS). CMS is the governmental agency within the Department of Health and Human Services that administers Medicare, and oversees states' administration of Medicaid. The agency's mission is to serve Medicare and Medicaid beneficiaries. The agency is structured around three centers that reflect the agency's major lines of business: the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.
COB - Coordination of Benefits	Coordination of Benefits (COB) is a contract provision that applies when a person is covered under more than one group medical program. It requires that payment of benefits will be coordinated by all programs to eliminate over-insurance or duplication of benefits. (The 'primary' plan pays first; the difference is paid by the 'secondary' plan.)
COBRA - Consolidated Omnibus Budget Reconciliation Act	A federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and beneficiaries whose group health insurance coverage has been terminated. It applies to employers with 20 or more eligible employees. It typically makes continued coverage available for up to 18 or 36 months. COBRA enrollees may be required to pay 100 percent of the premium, plus an additional two percent.
COC - Certificate of Coverage	A Certificate of Coverage (COC) is a description of the benefits included in an individual's plan. The COC is required by state laws and represents the coverage provided under the contract issued to the employer.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
Coinsurance	Coinsurance is the portion of covered health care costs the covered person is financially responsible for, usually according to a fixed percentage. Coinsurance is often applied, according to a fixed percentage, after a deductible requirement is met.
COMET	Uniprise is sponsoring the development of COMET - a user-friendly, Web-based system that will revolutionize claim processing. The COMET workstation is a single workstation that will be used regardless of claim adjudication platform. It will: • Increase processing efficiency by providing access to separate systems for relevant information. • Create a "smart" application that will guide claim processors through a claim. • Improve quality, thereby providing increased customer service and satisfaction. • Decrease staff learning curves by eliminating the training required for complex navigation of multiple systems, providing the ability to set up detailed competency-based processor criteria, and by providing the ability to test/practice using "real life" scenarios. • Provide improved management tools for working claim inventories. • Maximize telecommuting capabilities by providing a quicker way to access key information for processing claims, and allowing telecommuters to pay claims on both platforms.
CPSA - California Physicians' Service Agency	We have a network access agreement with California Physicians' Service Agency, Inc. (CPSA), a wholly owned subsidiary of Blue Shield of California. As a result, UnitedHealthcare subscribers and dependents in California obtain access to physicians and hospitals through the CPSA leased network.
CPT - Current Procedural Terminology	The Physician's Current Procedural Terminology (CPT) is a list of medical services and procedures performed by physicians and other health care professionals. Each service and/or procedure is identified by its own unique five-digit code. CPT has become the health care industry's standard for reporting procedures and services, and the codes are widely used by physicians and hospitals. The list is maintained by the American Medical Association (AMA), and is also referred to as HCPCS Level I codes.
CPT-4 - Current Procedural Terminology, 4th Edition	Physician's Current Procedural Terminology, 4th Edition (CPT-4) is a book that contains five-digit CPT codes, which provide a categorized (by body system or function) listing of physicians' procedures.
CRQC – Claim Rework Quality Council	The Claims Rework Quality Council is a Uniprise initiative committed to reducing claim rework sourced in manual claim processing.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
CSP - Customer Sponsored Provider	A Customer Sponsored Provider Network (CSP) is a contract held between the employer group and the provider organization, not between UnitedHealthcare and the provider organization.
CSR - Customer Service Representative	A Customer Service Representative (CSR) is a member of the Service organization responsible for answering simple and complex calls from physicians, other health care professionals, enrollees and their dependents.
CVC - Coordinated Vision Care	Coordinated Vision Care (CVC), also referred to as VBM (Vision Benefits Management company), provides network-based vision care services and hardware (frames and lenses). Coordinated Vision Care, Inc. is a wholly owned subsidiary of Specialized Care Services, Inc. CVC is now part of Spectera. See Spectera.
CVO – Credentialing and Verification Organization	An out-sourced, licensed organization that provides a credentialing process for all vision care network health care professionals before they are accepted into the network.
CVS ProCare	CVS ProCare is a vendor that provides specialty pharmacy services. They are our preferred vendor for self-administered injections and specialty medications. Examples of specialty medications are Lupron Depot, Synagis, Synvisc and Hyalgan. CVS ProCare will ship to an individual's home (self-administered injections) or a physician's office (specialty medications).
DBP - Dental Benefit Providers	Dental Benefit Providers (DBP) provides network-based dental insurance and management services. DBP has subsidiaries in California, Illinois, New Jersey and Maryland.
DED - Deductible	Deductible (DED) is a portion of the benefits, under a policy, that the employee and dependents must satisfy before any reimbursement occurs. This is called the individual deductible.
DOI - Department of Insurance	Department of Insurance (DOI). Each state has such a department that provides oversight management and support within the insurance industry.
DOL - Department of Labor or Date of Loss	1) Branch of government providing regulatory procedures & guidance on various labor topics. 2) Date of Loss is the first day of verified disability after the last day worked.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
DRG - Diagnostic Related Groups	Diagnostic Related Groups (DRG) is a system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, gender and presence of complications. This system of classification is used as a financing mechanism to reimburse hospitals and selected other health care professionals for services rendered, typically based on the average cost of all patients within the DRG.
EAP - Employee Assistance Program	Services provided through a third party vendor, designed to assist employees, their family members, and employers in finding solutions for workplace and personal problems. Services may include assistance for family/marital concerns, legal or financial problems, elder care, childcare, substance abuse, emotional/stress issues and other daily living concerns. EAPs may address violence in the workplace, sexual harassment, dealing with troubled employees, transition in the workplace and other events that increase the rate of absenteeism or employee turnover, or lower productivity. The EAP addresses issues that affect employee morale or an employer's productivity or financial success. EAPs also can provide the voluntary or mandatory access to behavioral health benefits through an integrated behavioral health program.
EOB - Explanation of Benefits	The Explanation of Benefits (EOB) is a statement provided by the health benefits administrator to the individual or physician/other health care professional that explains the benefits provided, the allowable reimbursement amounts, deductibles, coinsurance, or other adjustments taken, and the net amount paid. A participant typically receives an EOB with a claim reimbursement check or as confirmation that a claim payment has been made directly to the physician/other health care professional. COSMOS users refer to the physician/other health care professional EOB as PRA (Provider Remittance Advice).
EOD - Explanation of Denial	Explanation of Denial (EOD) is the narrative description sent to the physician/other health care professional or individual for denied services. This narrative description is almost always in the form of a letter.
EOMB - Explanation of Medicare Benefits	Explanation of Medicare Benefits (EOMB) is an EOB produced by Medicare for Medicare participants.
EPD - Expanded Provider Database	The Expanded Provider Database (EPD) supports both COSMOS and UNET and is a mainframe provider database that contains physician and other health care professional demographic and credentialing data, service and billing addresses, and contract information, including rates. It includes the EPD Procedure Maintenance File and pro/tech splits (maintained by Belinda Jones).

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
EPO - Exclusive Provider Organization	A term derived from the phrase preferred provider organization (PPO). However, where a PPO generally extends coverage for non-preferred provider services as well as preferred provider services, an EPO provides coverage only for contracted providers. Technically, many HMOs also can be described as EPOs. A plan that provides coverage for services only from contracted physicians and other health care professionals These plans require a primary physician to act as a gatekeeper for coordinating the individual's care. When the primary physician provides or coordinates care with another network physician or other health care professionals, the individual will receive the highest level of benefits. When the individual does not go through the primary physician, the individual must pay all costs. This plan has a high level of medical management.
ESRD - End Stage Renal Disease	End Stage Renal Disease.
Evidence Based Medicine	Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.
FFS - Fee For Service	Fee For Service (FFS) is a reimbursement method where payment is made based on the charges for services. This is unlike capitation where payment is made based on the number of individuals in a physician's or other health care provider's practice that receive benefits or are insured through the company making payment.
FI – Fully Insured	The accounts/employer groups that assume only the financial risk for the payment of monthly employee premiums, and where the carrier assumes full risk for actual medical expenses incurred. Fully insured accounts are subject to all state and federal regulations.
FSA - Flexible Spending Account	Flexible Spending Account (FSA) is an account that allows individuals to set aside pretax dollars to pay for health care and day expenses not covered by insurance. Funds are deposited into an employee-specific account.
GSP - Group Specific Provider Network	A Group Specific Provider Network (GSP) is a contract held between UnitedHealthcare and the provider organization. However, the terms of the agreement (access and/or rates) are limited to one or more employer groups.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
HCPCS	Like CPT, the HCFA Common Procedural Coding System (HCPCS) is a listing of services, procedures, and supplies offered by physicians and other health care professional. However, HCPCS includes not only CPT codes (“Level I codes”), but also national codes (“Level II codes”) and local codes (“Level III codes”). The national codes are developed by HCFA as a supplement to CPT codes, addressing physician services not included in CPT, as well as non-physician services such as ambulance, physical therapy and durable medical equipment. The local codes are developed by local Medicare carriers to supplement the national codes. HCPCS codes are five-character codes; the first character is a letter that is followed by four numbers. HCPCS codes beginning with A-V are national; those beginning with W-Z are local. Physicians, hospitals, and other health care professionals use HCPCS codes to report services rendered. If not otherwise specific, the term "HCPCS" normally refers to Level II HCPCS codes.
HCPCS Level I	Healthcare Common Procedural Coding System (HCPCS) Level I code - preferred term is CPT codes.
HCPCS Level II	Healthcare Common Procedural Coding System (HCPCS) Level II codes are used by all states.
HCPCS Level III	Healthcare Common Procedural Coding System (HCPCS) Level III codes are the state or local codes assigned by and for Medicare claims processing. UnitedHealth Group does not accept claims with Level III HCPCS codes. BIPA provisioning allowed codes to be retained until December 31, 2003 if necessary due to state mapping that was required due to HIPAA requirements.
HEDIS - Health Plan Employer Data and Information Set	Health Plan Employer Data and Information Set (HEDIS) is a core set of performance measures managed by the National Committee for Quality Assurance to assist employers and other health purchasers in evaluating health plan performance. It also is used by the Health Care Financing Administration (HCFA) to monitor quality of care given by managed care organizations.
HIPAA - Health Insurance Portability and Accountability Act	A federal law intended to improve the availability and continuity of health insurance coverage that, among other things, places limits on exclusions for pre-existing medical conditions; permits certain individuals to enroll for available group health care coverage when they lose other health coverage or have a new dependent; prohibits discrimination in group enrollment based on health status; provides privacy standards relating to individuals’ personally identifiable claim-related information; guarantees the availability of health coverage to small employers and the renewability of health insurance coverage in the small and large group markets; and requires availability of non-group coverage for certain individuals whose group coverage is terminated.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
HMO - Health Maintenance Organization	A Health Maintenance Organization (HMO) is a network of physicians and other health care professionals that provides or coordinates an individual's health care services. Physicians that participate within the HMO network are reimbursed on a flat rate monthly basis based on specific capitation models. Individuals pay a specific copayment based on the benefit plan design.
HSA – Health Savings Account or Health Service Agreement	HSAs allow consumers and employers to make tax-free contributions to interest-bearing accounts, which may then be used to pay for qualified health care expenses or for non-health care expenses (subject to applicable taxes and penalties). HSAs must be coupled with high-deductible health plans that meet certain Internal Revenue Service requirements. Since high-deductible health plans typically feature lower premiums than traditional plans, the high-deductible health plan/HAS combination is an effective means for many individuals to save money and spend their health care dollars more efficiently. Health Service Agreement - a document, including any related application and addenda, which specifies the benefits, exclusions and other conditions between the health plan and the enrolling group
ICD–9 - International Classification of Diseases, 9th Edition	The International Classification of Diseases, 9th Edition (ICD-9) is a book that contains a categorized listing of diseases, procedures, and classification of circumstances. ICD-9 diagnosis codes are three to five digits in length. Physicians and hospitals use these codes to report diagnosis and procedure code information. ICD codes are updated each fall in October. ICD-9-CM (Clinical Modifications) is the version used by UnitedHealth Group and most insurers.
IPA - Individual Practice Association	Individual Practice Association (IPA) HMO is a health care model that contracts with an entity, which in turn contracts with physicians to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
JCAHO - Joint Commission on Accreditation of Healthcare Organizations	An independent, private, not-for-profit organization that evaluates, sets standards for, and accredits hospitals, health plans and other health care organizations providing home care, mental health care, ambulatory care and long term care services.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
Medco Health	UnitedHealthcare Pharmacy Management has contracted with Medco for services and systems support in the administration of our pharmacy program, including home delivery services. All aspects of pharmacy benefit management, including management of the prescription drug list, are overseen by UnitedHealthcare. The only situation where the Medco brand is visible to enrollees is when they choose to use Medco's home delivery services. Pharmacy information can be found at myuhc.com where enrollees and their dependents can learn about their own benefit plan, participating pharmacies, and home delivery prescription benefit services.
MNRP – Maximum Non-Network Reimbursement Program	Beginning with renewal dates on or after January 1, 2004, UnitedHealthcare is introducing a new, standard approach to reimbursing non-network physicians, facilities and other health care professionals. (Note: The timing of implementation depends on approval of the 2001 COC and the 2002 COC Amendment). Instead of basing non-network reimbursement on uncontrolled, charge-based prevailing fees, UnitedHealthcare will reimburse non-network expenses according to Medicare's cost-based payment methodology. Under this new approach, reimbursement for non-emergency treatment is a percentage of the published rates allowed by Medicare for the same or similar services.
myuhc.com - A UnitedHealthcare Website	UnitedHealth Group's online site to benefits and claims information available to employees and enrollees.
NCQA - National Committee for Quality Assurance	NCQA is an independent, 501(c)(3) non-profit organization whose mission is to assess and report on the quality of managed care plans. They provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed health care purchasing decision. Our efforts are organized around two activities, accreditation and performance measurement, which are complementary strategies for producing information to guide choice. (The definition for NCQA should really be closer to the JCAHO definition since the desired outcome of both entities is the same).
NCQR - National Claim Quality Review	National Claim Quality Review (NCQR) is UnitedHealth Group's National Claim Quality Review system. NCQR is used in our claim offices across the country to review and ensure the quality of our claim processing. NCQR is an automated, Intranet-based application that randomly selects claims from each of the claim processing platforms (UNET and COSMOS), and presents these claims to specially trained quality coaches for review and grading. When detected, errors are recorded and results are presented back to each office.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
NDB - Network Database	Provides enhanced capability and efficiency for physician and health care professional information with releases focused on upgraded infrastructure, demographic maintenance and strategic contracting.
NOBLX	A term often used in Uniprise that refers to the Non-Office Based Lab and X-ray. This is the outpatient lab and x-ray that occurs in places of service other than an office or outpatient surgery.
Non – PAR - Non-Participating Provider	Non-PAR refers to a non-participating physician or health care professional. This describes a physician or other health care professional that has not contracted with the carrier or health plan to be a participating provider of health care. Also known as an out-of-network, or non-network physician or health care professional
NYHCRA - New York Health Care Reform Act	The New York Health Care Reform Act (NYHCRA) imposes certain surcharges and assessments on a variety of health care physician/other health care professional services. The surcharges and assessments collected are used to finance bad debt, graduate medical education (GME) and a variety of other health care initiatives.
OBRA - Omnibus Budget Reconciliation Act	Omnibus Budget Reconciliation Act.
Overture	A Key Accounts tiered-benefit product whereby two or three plan designs are offered together and employees have the option of choosing one of the levels of benefits.
PAR – Participating Physician, Hospital, Pharmacy	PAR - Participating physician or healthcare professional who has contracted with the health plan to deliver medical services to covered persons. These may include physicians, hospitals, pharmacy, other facility or other health care professionals who has contractually accepted the terms and conditions set forth by the health plan.
PARS – Patient Advocate Review System	The Patient Advocate Review System is the utilization and management component of UNET and COSMOS that captures and manages referrals and inpatient and service notifications. It also provides case management capabilities, and access to medical protocols and guidelines. It is the care coordination/notification system that feeds to both COSMOS and UNET.
PCP - Primary Care Physician	Primary physician has replaced the term Primary Care Physician (PCP). See PP.
POC - Percent of Charge	Percent of Charge, or Percentage of Charge (POC) is a physician or other health care professional contract to allow reimbursement based on a percentage of a physician's or other health care provider's billed amount rather than a fixed contracted rate. On COSMOS, POC-contracted physicians/other health care professionals are normally referred to as discount providers.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
POS - Place of Services or Point of Service	1) Place of Services is the location of medical/surgical services rendered, such as physician office, hospital outpatient department or emergency room. The standard code is the HCFA two-digit place of service codes (such as OF Office). 2) Point of Service plan is a health benefit plan allowing the covered person to choose to receive service from a participating or non-participating physician or other health care professionals, with different benefit levels associated with the use of participating physicians/other health care professionals. These plans require a primary physician to act as a gatekeeper for coordinating the individual's care. When the primary physician provides or coordinates care with another network physician or other health care professionals, the individual will receive the highest level of benefits. When the individual does not go through the primary physician, the individual receives a lesser benefit, which means more out-of-pocket costs for the individual. When individuals bypass the primary physician, this bypass option is called OPT-OUT. This plan has a medium level of medical management.
PPO - Preferred Provider Organization	A program that establishes contracts with providers of medical care. Physicians and other health care professionals under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits and lower costs for services received from preferred physicians and other health care providers, thus encouraging covered persons to use these physicians and health care professionals. Covered persons generally are allowed benefits for non-participating physician and other health care professional services, usually on an indemnity basis. There is no requirement to elect a primary physician to serve as a gatekeeper for network services. UnitedHealthcare's PPO products are called "Options."
QA - Quality Assurance	Quality Assurance (QA) refers to a formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services. Federal and state HMO acts typically require plans to have quality assurance programs.
R&C - Reasonable and Customary	Reasonable and Customary (R&C) is a term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community. R&C creates a maximum that is allowed for a particular service based on the geographical area and the charges for the same service within that area. This data is collected, compiled and an R&C amount is determined. Also referred to as Usual and Customary, or Usual, Customary and Reasonable (UCR).
RVS - Relative Value System	Relative Value System (RVS) is used to compare the relative complexity of one medical service to another. Some common examples are: RBRVS, St Anthony's, and 64 RVS.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
SCS - Specialized Care Services	Specialized Care Services (SCS) is UnitedHealth Group's portfolio or businesses that offer unique and specialized health and wellness benefits and services to UnitedHealth Group health plans, health plans not owned by UnitedHealth Group, self-insured employer groups and government agencies.
Select	Select refers to products that require selection of a primary physician and do not have an out-of-network component. UnitedHealthcare Select HMO, and UnitedHealthcare Select EPO are examples of Select products. See EPO for more information.
Select Plus	Select Plus refers to products that require selection of a primary physician and have an out-of-network component. UnitedHealthcare Select Plus POS, and UnitedHealthcare Select Plus HMO are examples of Select Plus products. See POS for more information.
SG&A - Selling, General and Administrative	All operating costs associated with employee salaries, general and administrative expenses such as facilities, supplies, equipment, travel and advertising.
TPA - Third Party Administrator	Third Party Administrator (TPA) is an independent person or corporate entity (third party) that administers group benefits, claims and administration for a self-insured company/group. A TPA does not underwrite the risk.
U.R.N. - United Resource Networks	United Resource Networks (U.R.N.) provides specialized solutions for complex medical conditions. Our Centers of Excellence networks and clinical consulting services are available for the management of transplant, congenital heart disease (CHD) and complex cancer patients. Our portfolio of products includes Transplant Resource Services, CHD Resource Services, Cancer Resource Services, EnvisionCare Alliance case management and Specialized Physician Review medical appropriateness opinion services.
UB-92 - Uniform Billing Code-1992	Uniform Billing Code of 1992 (UB-92) is a revised version of UB-82, a federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice, which was implemented Oct. 1, 1993.
UBH - United Behavioral Health	United Behavioral Health (UBH) is part of the Specialized Care Services business segment and provides network–based employee assistance and mental health/substance abuse services. UBH's legal entities include U.S. Behavioral Health Plan California, Behavioral Health Administrators, United Behavioral Health of New York, I.P.A., Inc., and Working Solutions, Inc.
UCR - Usual, Customary and Reasonable	Usual, Customary and Reasonable (UCR). See R&C.

UnitedHealthcare
Terms and Acronyms

Acronym/Term	Definition
UHN - UnitedHealth Networks	Part of the UnitedHealthcare business segment, UHN supports a wide spectrum of operations: Care Coordination, Credentialing, Pacific Region and Extended Markets, Network Development, Network Partner Services, Pharmacy, Provider Information Management (PIM), physician contracting, physician Relations, Regional Audit & Recovery (RAR) and Network Reimbursement.
UNET	Claims Processing System for Key Accounts broker information and claims. It supports multi-site cases with single administration and single site business for some products and locations. UNET is not an integrated system. Components of UNET are coupled together. This means that a record may exists in several places in UNET, each supporting a different function. (I believe the definition could really be the same as COSMOS, even though UNET is now just KA, the end result is that both KA and SB will migrate to unitedPlatform.) Different sub-systems tied to UNET are TOPS, UNET Front End, PRS, PRIME, EPD, PARS, CES, ACIS and EBDS.
Unimerica Workplace Benefits	Unimerica Workplace Benefits is a subsidiary of Specialized Care Services, Inc., and provides life, accident and critical illness coverage.
UR - Utilization Review	Utilization Review (UR) is a formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
VRU - Voice Response Unit	Voice Response Unit (VRU). See Telephone Self-Service.
Warm Transfer	A warm transfer is used when callers need to be referred to another service center. The customer service representative gives the caller the correct toll free number for future use, informs them that they will be transferred, and then dials the correct toll free number. The representative stays on the line until a representative at the correct site answers the call. The sending representative informs the correct office representative of who is on the line, why the call is being transferred, and of any other pertinent information available. The caller is then put through for service at the correct site.
WebMD	WebMD is now UnitedHealth Group's largest Electronic Data Interchange (EDI) vendor that allows individual physicians and other health care professionals to submit claims electronically. WebMD funnels claims to all the insurance carriers necessary in the format preferred by the carrier.