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Palliative Care	Palliative care strives to alleviate discomfort and pain to improve the quality of life for patients. Palliative care can be provided during any stage of an illness and most frequently to patients with life-limiting illness. It can be provided at the same time as curative care.
Palmetto GBA	**Palmetto GBA** serves as the Part A and Part B Medicare Administrator Contractor (MAC) for the jurisdictions that include West Virginia.
Partial Hospitalization	Partial hospitalization programs are defined as structured and medically supervised day and evening programs. Although the patient is not considered a resident, the services provided are of similar nature and have similar intensity to those provided as an inpatient. The services offered are designed to address a mental health and/or substance abuse disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.
Participating Provider	A health care provider who has been contracted to give medical services or supplies to health plan members for a pre-negotiated fee.
Partners in Quality Tool Kit	The Partners in Quality Tool Kit was developed as a resource for network participating office sites to assist in promoting quality health care to their patients and members. The tool kit includes a variety of educational resource materials, such as age specific progress records, preventive health records, and sample office policies to assist the practitioner in meeting Highmark standards, including medical record documentation. Member-specific educational materials are also available for physicians to assist their patients with preventive health care.
Patient-Centered Medical Home (PCMH)	The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care in a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family or caregiver. A practice-based care team led by the primary care practitioner (PCP) coordinates all the care for the patient. The medical home is responsible for tracking and monitoring the patient as he or she moves throughout the health care system. This is to ensure that the appropriate care is being provided.
Patient Protection and Affordable Care Act of 2010 (PPACA)	On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), often shortened to "Affordable Care Act" (ACA), was signed into law. Many changes will take place in health care over the next decade due to provisions of this law better known as Health Care Reform. Most significantly, the Affordable Care Act is intended to expand health insurance options for Americans who lack coverage.

Peer-to-Peer Review	A peer-to-peer review is a process that offers the member's attending physician the opportunity to present additional pertinent clinical information to support the authorization of a requested service prior to initiating a formal appeal. It is provided when a medical necessity denial has been rendered without a peer-to-peer conversation about the request or when additional information has become available.
Point of Service (POS)	A managed care benefit program in which members select a PCP and maximize benefit coverage by securing care directly from, or under authorization by, the selected PCP. Members may incur additional out-of-pocket cost or reduced benefits for using non-network providers.
Pre-Authorization	The process in which a member or provider must contact the health plan prior to a non-emergency hospitalization or other selected services in order to receive authorization for these services.
Pre-Existing Condition	A condition for which medical advice, care, treatment, or diagnosis has been recommended or received from a provider within a designated time period immediately preceding the effective date of health plan coverage.
Pre-Existing Waiting Period	A specified time period when the health plan does not cover a member's pre-existing condition(s).
Pre-Service Denial	A pre-service denial occurs when a physician tells a member that a specific requested service cannot be provided or continued due to lack of medical necessity or because the service is a non-covered benefit. If the member accepts the physician's decision, this is not a pre-service denial. If the member agrees with the physician's decision not to supply the service at the time of the visit, but later reconsiders and decides that he or she wants to have the service, this is a pre-service denial.
Preferred Provider Organization (PPO)	Preferred provider organization (PPO) programs typically offer members the ability to obtain care from a network participating provider at the higher in-network level of benefits and without the requirement to select a primary care physician. Members may also receive care from providers not participating in the network for which the services will be reimbursed at the lower, out-of-network level of benefits. In addition to deductible and coinsurance, the member would be responsible for the difference between the provider's charges and the actual payment provided by Highmark. All services are subject to specific contract coverage and limitations.
Prefix	The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage. **Note:** Previously called "alpha prefix" since all 3 characters were alpha characters; prefixes with alphanumeric characters are started being issued to Blue Plans by the BlueCross Blue Shield Association in 2018 when requested for new products.

Premier Blue Shield Network	The Premier Blue Shield Network is Highmark's statewide selectively contracted preferred provider network in Pennsylvania. Any eligible professional provider licensed to practice medicine in Pennsylvania may apply for the Premier Blue Shield network. The network's credentialing criteria must be met to be accepted into the network.
Premium	Payment or series of payments made to a health plan by a group, an employer, or a member for health care benefits.
Preventive Care Benefits	Preventive benefits are offered in accordance with a predefined schedule based on age, sex, and certain risk factors. Benefits are provided for periodic physical examinations, immunizations, and selected diagnostic tests, and are covered regardless of medical necessity but have proven clinical value when performed on a routine basis.
Primary Care Physician/ Practitioner (PCP)	PCP is the acronym for "primary care physician" or "primary care practitioner" -- a practitioner selected by a member in accordance with the member's managed care program requirements. The practitioner provides, coordinates, or authorizes the health care services covered by the managed care program. The PCP may be a general practitioner, family practitioner, internist, certified registered nurse practitioner (CRNP), or pediatrician.
Privileging	Privileging is a process that addresses the quality of imaging services performed at an imaging center or in a physician's office. All professional providers who perform imaging services in Pennsylvania must be privileged. In Pennsylvania, non-privileged providers are not eligible for reimbursement of imaging services.
Product and Program	When used in this manual, program and product have approximately the same meaning, but somewhat different usage. They both refer to the patient's type of insurance coverage. Program refers to the type of coverage (e.g., HMO, PPO, POS), whereas product refers to the brand name of the program (e.g., *PPO Blue, Blue Select,® Blue Care,® Freedom Blue*).
Protocol	The plan for a course of medical treatment.
Provider	A provider is a Highmark assigned health care professional, institution, or organization in whose name the bill is submitted and to whom payment should be made.
Provider News	*Provider News* is Highmark's bimonthly informational newsletter for health care professionals and facilities, and their office staffs, who participate in our networks and submit claims to Highmark using the 837P/837I HIPAA transactions or 1500/ UB-04 claim forms. This newsletter conveys important product and administrative news including billing, claims, and program updates. *Provider News* also offers tips and reminders, and it provides information about Highmark tools and resources. This publication may also contain administrative requirements, policies, procedures, or other similar requirements of Highmark that are binding upon Highmark and its contracted providers.

Provider Resource Center (PRC)	The Provider Resource Center (PRC) is a special section of our website that is specifically dedicated to Highmark participating providers and contains lots of helpful information and resources to help in your daily interactions with Highmark members and with Highmark.
ProView™	Proview™ is the online credentialing database developed by the Council for Affordable Quality Healthcare (CAQH). The CAQH ProView national standardized online system eliminates the need for multiple credentialing applications and significantly streamlines the credentialing process. Practitioners complete one standard application that meets the needs of Highmark and other participating health plans and health care organizations.
Prudent Layperson	A prudent layperson is one who is without medical training and who draws on his or her practical experience when deciding whether emergency medical treatment is needed.