

# Glossary

These definitions are general definitions applied for purposes of this manual. State law, certain practitioner agreements and individual benefit contracts define some of these terms differently. In such cases, the definitions contained in the applicable law or contract will supersede these definitions.

**Adverse Determination:** A denial, reduction, or termination of coverage, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on the eligibility of a member or beneficiary to participate in a plan; and a denial resulting from utilization review, the experimental or investigational nature of the service, or the lack of medical necessity or appropriateness of treatment.

**Algorithm:** A set of decision rules CHIPA applies to member-specific data to determine if there are any targeted clinical issues or risks.

**ALgorithms for Effective Reporting and Treatment (ALERT®):** An outcomes-based system using member responses to a validated survey, in conjunction with claims data, for the identification of members who are at moderate to high risk for poor clinical outcomes.

**All-Payer Contract:** An arrangement allowing for payment of health services delivered by a contracted Clinician regardless of product type (e.g., HMO, PPO) or revenue source (e.g., fully funded or self-funded).

**Appeal:** A specific request to reverse an adverse determination or potential restriction of benefit reimbursement.

**Balance Billing:** The practice of a Clinician or POD/Group requesting payment from a member for the difference between the CHIPA contracted rate and the Clinician or POD/Group's usual charge for that service.

**Behavioral Health Care:** Assessment and treatment of mental health and/or substance abuse (MH/SA) disorders.

**Intake Specialist:** A CHIPA employee who is a licensed clinical professional (e.g., nurse, doctor, psychologist, social worker, or professional counselor) who works with members, health care professionals, physicians, and insurers to maximize benefits available under a member's benefit plan.

**Certification:** The number of inpatient days or non-routine outpatient visits for which benefits have been applied as part of the member benefit plan for payment (formerly known as an Authorization). Certifications are not a guarantee of payment. Final determinations will be made based on member eligibility and the terms and conditions of the member's benefit plan at the time the service is delivered (Also see "Open Certification").

**Clean Claim:** meets the following conditions:

- Is sent on a CMS 1500 claim form, or an accepted electronic equivalent (National Standard Format Version 2.0)
- The information requested by CHIPA (i.e., authorized CPT code, ICD-9 code, rendering provider's tax ID number) is present and legible on the CMS 1500 or an

- accepted electronic equivalent) and the form is 100% complete with no missing or illegible information
- The claim is sent by a CHIPA and appropriate Payer contracted provider or provider group. The provider must be in “good” and “active” status in both panels or have signed a Single Case agreement (SCA) with CHIPA.

**Clinician:** A licensed professional that has contracted to deliver behavioral health care services to members (also known as a network Clinician).

**Coinsurance:** The portion of covered health care costs the member is financially responsible for, usually according to a fixed percentage. Coinsurance often is applied after a deductible requirement is met.

**Co-payment:** A cost-sharing arrangement in which a member pays a specified charge for a specified service, such as \$20 for an office visit, for example. The member usually is responsible for payment at the time the health care is rendered. Typical co-payments are fixed or variable flat amounts for Clinician office visits, prescriptions or hospital services. Sometimes the term "co-payment" generically refers to both a flat dollar co-payment and coinsurance (see above).

**Credentialing:** The process by which a Clinician or POD/Group is accepted into the applicable Health plan network and by which that association is maintained on a regular basis.

**Deductible:** The annual amount of charges for behavioral health care services, as provided in the member's benefit plan, which the member is required to pay prior to receiving any benefit payment under the member's plan.

**EAP (Employee Assistance Program):** Services that are designed for brief intervention, assessment and referral. These services are short-term in nature.

**Electronic Claim:** Is a claim formatted as an electronic data file, which is transmitted via a data connection rather than printed on a form and mailed.

**Electronic Claim Submission:** Is the use of an Electronic Data Interface (EDI) to submit electronic claims for processing.

**Electronic Data Interface (EDI):** Is the information technology, which allows acceptance of the electronic data file.

**Emergency:** A serious situation that arises suddenly and requires immediate care and treatment to avoid jeopardy to life or health. For appointment access standards see “Emergency - Life-threatening”, “Emergency — Non-life-threatening” and “Urgent”.

**Emergency — Life-threatening:** A situation requiring immediate appointment availability in which there is imminent risk of harm or death to self or others due to a medical or psychiatric condition.

**Emergency — Non-life-threatening:** A situation requiring appointment availability within six hours in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm or death to self or others.

**Exclusions:** Specific conditions or circumstances listed in the member’s benefit plan for which the policy or plan will not provide coverage reimbursement under any circumstances.

**Facility:** An entity that provides inpatient, residential, or ambulatory services and has contracted to deliver behavioral health care services to members (also known as a network facility).

**Facility Contract Manager:** A CHIPA professional dedicated to managing contractual relationships with hospitals and freestanding behavioral health programs and services for the CHIPA network.

**Fee Maximum:** The maximum amount a participating Clinician or facility may be paid for a specific health care service provided to a member under a specific contract. CHIPA reimburses Clinicians based upon licensure rather than degree.

**Health Plan:** A health maintenance organization, preferred provider organization, insured plan, self-funded plan, or other entity that covers health care services. This term also is used to refer to a plan of benefits.

**HIPAA:** The Health Insurance Portability and Accountability Act, by which a set of national standards are set for, among other topics, the protection of certain health care information. The standards address the use and disclosure of an individual’s “Protected Health Information” (PHI) by organizations subject to the Privacy Rule (“covered entities”). These standards also include privacy rights for individuals to understand and control how their health information is used. For more information, please visit the Department of Health and Human Services Web site at [www.hhs.gov](http://www.hhs.gov).

**Independent Review Organization:** An independent entity/individual retained by a private health plan, state agency or federal agency to review adverse determinations (based on medical necessity) that have been appealed by, or on behalf of, a member (also sometimes known as External Review Organizations).

**Least Restrictive Level of Care:** The Level of Care (LOC) at which the patient can be safely and effectively treated while maintaining maximum independence of living.

**Level of Care (LOC) Guidelines:** Objective, evidence-based admission and continuing stay criteria for MH/SA services. These guidelines are intended to standardize care advocate decisions regarding the most appropriate and available level of care needed to treat a member’s presenting problems.

**Medical Necessity:** Generally, the evaluation of health care services to determine if they meet plan criteria for coverage as medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to member benefit plans or state laws (also referred to as Clinical Necessity).

**Member:** An individual who meets eligibility requirements and for whom premium payments for specified benefits of the contractual agreement are paid. Also may be referred to as a plan participant or enrollee.

**MH/SA:** Mental Health and/or Substance Abuse.

**Network Management:** Consists of CHIPA Network Managers and Associates who provide service to CHIPA network Clinicians and facilities. Additionally, they work with Care Advocacy, Account Management and Sales to contract and retain experienced mental health and substance abuse treatment professionals.

**Open Certification:** Usually issued directly to members, this 12-calendar-month certification is not specific to any one particular network Clinician and covers most routine outpatient psychotherapy services.

**Participation Agreement:** A contract describing the terms and conditions of the contractual relationship between CHIPA and a Clinician or POD/Group under which mental health and/or substance abuse services are provided to members.

**Payer:** An organization that pays for health care expense coverage.

**Quality Assurance:** A formal set of activities to review and affect the quality of services provided. Quality assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient services. Federal and state regulations typically require health plans to have quality assurance programs.

**Quality Improvement:** A continuous process that identifies opportunities for improvement in health care delivery, tests solutions, and routinely monitors solutions for effectiveness.

**Rejected Claim:** does not meet one of the above conditions of a “clean claim”.

**Routine:** A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others.

**Urgent:** A situation in which immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation. Availability should be within 48 hours or less or as mandated by state law.

**Wellness Assessment (WA):** A reliable, confidential, member-driven instrument used to help identify targeted risk factors in addition to establishing a baseline for tracking clinical change and outcomes.

