

Glossary and Abbreviations

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Glossary of Health Care Terms

Several health care terms in this glossary have two types of definitions:

- **Health care industry definitions**—identified in the glossary with the symbol HCID

HCID

-explains these terms in language commonly used and generally accepted by the health care industry, including UPMC Health Plan.

- **Statutory/regulatory definitions**—identified in the glossary with the symbol SRD

SRD

-explain these terms in language that is mandated by law or regulatory agencies.

The glossary is not intended to be all-inclusive, but it does cover most of the key terms encountered in this manual.



Alert

If a term has a “statutory/regulatory” definition, that definition takes Precedence over any “health care industry” definition.

Copayment

HCID

Cost-sharing arrangement in which the member pays a specified flat amount for a specific service (such as an office visit or prescription drugs).

Covered Services

HCID

Health care services for which a health plan approves payment according to the benefit package purchased by the member.

Credentialing

HCID

UPMC Insurance Services Division's review procedure that requires that potential or existing network providers meet certain standards in order to begin or continue participation in the network of the Health Plan. The credentialing process may include examination of a provider's certifications, licensures, training, privileges, and professional competence.

D

Deductible

HCID

Amount member must pay for covered services before the health plan begins to pay for such services.

Disenrollment

HCID

Process of the termination of a member's coverage.

Durable Medical Equipment

SRD

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

E

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

SRD

Items and services which must be made available to Medical Assistance beneficiaries who are under the age of 21, including UPMC *for You* members, upon a determination of medical necessity and required by federal law at 42 U.S.C. §1396d(r).

Emergency Service

SRD

Any health care service provided to a member after sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the member (or for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service, if the condition of the member is as described above.

Enrollment

HCID

Process by which a health plan signs up groups and individuals for membership.

Evidence of Coverage

HCID

Legal document that sets forth all of the terms and conditions of a member's eligibility and coverage in a benefit plan. It includes the schedule of benefits that outlines covered services and provides information on such topics as the member's right to file a complaint or grievance and continuity of care.

Excluded Services

SRD

Health care services that the member's health insurance plan does not pay for or cover.

Exclusive Provider Organization (EPO)

HCID

Plan that blends elements of a traditional HMO with the elements of a PPO. Members are not required to select a PCP. Members receive care at any network provider or facility to ensure coverage.

Explanation of Benefits (EOB)

HCID

Statement sent to a member by the Health Plan that explains the benefits provided; the allowable reimbursement amounts; any deductibles, coinsurance, or other adjustments taken; and the net amount paid.

Explanation of Payment (EOP)

HCID

A summary of covered services for which UPMC Health Plan paid a provider. Also known as a remittance advice, the Explanation of Payment (EOP) shows the date of service, member, and procedure performed as well as all payment information, including explanation codes for those claims denied or returned for correction. The EOP can be located by accessing Provider OnLine at upmchealthplan.com/providers. Provider OnLine is available 24 hours a day, 7 days a week.

G

Grievance

SRD

Request by a member, or by a health care provider with written consent of a member, to have a managed care plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding a decision that:

- disapproves full or partial payment for a requested health care service,
- approves provision of a requested health care service for lesser scope or duration than requested, or
- disapproves payment for the provision of a requested health care service but approves payment for provision of an alternative health care service.

A grievance is not the same as a complaint.

H

Habilitation Services

SRD

Health care services that help a member keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Maintenance Organization (HMO)

SRD

An organized system that combines the delivery and financing of health care and that provides basic health services to voluntarily enrolled members for a fixed prepaid price.

Health Plan Employer Data Information Set (HEDIS)

HCID

A core set of performance measures developed and managed by the National Committee for Quality Assurance (NCQA) to assist employers and other purchasers in evaluating health plan performance. Also used by government agencies to monitor quality of care provided or arranged by health plans.

Home Medical Equipment (HME)

HCID

Medical equipment owned or rented by a member and placed in the home of that member to facilitate treatment and/or rehabilitation. HME was formerly known as durable medical equipment.

Hospice Services

SRD

Services to provide comfort and support for members and their families during the last stages of a terminal illness.

I

Indemnity Plan (also known as fee-for-service)

HCID

A health plan that reimburses a member of the plan for medical services based on bills submitted after services are rendered. It does not typically cover all outpatient services or preventive care programs. Usually no restrictions are placed on selecting providers or facilities, and members pay a percentage of the charge for services.

Integrated Delivery System

SRD

A partnership, association, corporation, or other legal entity that does the following:

- Enters into a contractual agreement with a health plan.
- Employs or contracts with health care providers.
- Agrees under its arrangement with the health plan to do the following:
 1. Provide or arrange for the provision of a defined set of health care services to members covered under a plan contract principally through its participating providers.
 2. Assume under the arrangement with the plan some responsibility for conducting, in conjunction with the plan and under compliance monitoring of the plan, quality assurance, utilization review, credentialing, provider relations, or related functions.

The IDS also may perform claims processing and other functions.

M

Medically Necessary

SRD

For Commercial Products

Services or supplies are determined to be medically necessary if they are:

- Commonly recognized throughout the provider's specialty as appropriate for the diagnosis and/or treatment of the member's condition, illness, disease, or injury; and
- Provided in accordance with standards of good medical practice and consistent with scientifically

based guidelines of medical, research, or health care coverage organizations or governmental agencies that are accepted by UPMC Insurance Services Division; and

- Can reasonably be expected to improve an individual's condition or level of functioning; and
- In conformity, at the time of treatment, with medical management criteria adopted by UPMC Insurance Services Division or its designee; and
- Not provided only as a convenience or comfort measure or to improve physical appearance; and
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

UPMC Insurance Services Division reserves the right to determine in its sole judgment whether a service meets these criteria and will be authorized for payment. Authorization for payment decisions shall be made by UPMC Insurance Services Division with input from the member's PCP or other provider performing the service. Independent consultation with a provider other than the PCP or attending physician may be obtained at the discretion of UPMC Insurance Services Division.

The fact that a physician or other health care provider may order, prescribe, recommend, or approve a service, supply, or therapeutic regimen does not, of itself, determine medical necessity and appropriateness or make such a service, supply, or treatment a covered service.

For Medical Assistance

Determinations of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, or post utilization basis, shall be in writing and be compensable under Medical Assistance. The Physical Health or Community HealthChoices Managed Care Organization (PH-MCO or

CHC-MCO) shall base its determination on medical information provided by the member, the member's family or caretaker, and the PCP, as well as any other providers, programs, and agencies that have evaluated the member.

- Medical necessity determinations must be made by qualified and trained providers. Satisfaction of any one of the following standards will result in authorization of the service:
The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability;
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.
- (Additionally for Community HealthChoices) Will provide the opportunity for a member receiving long term services and supports (LTSS) to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

Glossary of Terms and Abbreviations Prepared for the Behavioral Health Provider

The following terms and abbreviations are defined as they are used in the Behavioral Health Section of the UPMC Health Plan Provider Manual.



A

Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost to the managed care program or in reimbursement for services that are not medically necessary or that fail to meet professionally-recognized standards for health care; also UPMC Health Plan member practices that result in unnecessary cost to the managed care program.

Adverse determination

A determination as to whether or not requested or provided health care services are:

- Adequate and essential for the evaluation or treatment of a disorder as defined by standard diagnostic nomenclature (the most recent or approved version of either ICD or DSM).
- Consistent with the standards of good medical practice, required for other than convenience, and the most appropriate supply or level of service.

Adverse Event

An event involving member safety that must be reported to UPMC Health Plan and to other agencies as appropriate; also known as Significant Member Incidents.

ALOS

Average length of stay at a hospital or treatment program.

Appeal

A request to reconsider and change a proposed resolution to a complaint. It is UPMC Health Plan's Proposed Resolution to a Complaint that is the subject of the Appeal.

ASAM

American Society for Addiction Medicine; ASAM principles and level-of care criteria constitute UPMC Health Plan's medical necessity criteria for adolescent chemical dependency.

Assessment

The process that facility providers complete similar to credentialing for individual behavioral health practitioners.

Authorization

An agreement that the services planned for a specific member meet Medical Necessity (level of care) Criteria; a provider must receive authorization to provide certain behavioral health services for a claim to be honored, but receiving authorization is **not** a promise that the claim will be paid— other criteria must be met.

C

CARF

Committee on Accreditation of Rehabilitation Facilities.

CMS

Center for Medicare and Medicaid Services.

COA

Council on Accreditation.

Complaint

An individual who expresses dissatisfaction with UPMC Health Plan or its affiliate Community Care, a provider, or other entity, verbally or in writing; a Complainant may include members, subscribers, practitioners, family members of a member and member representatives among others.

Coordination of care

Coordination of behavioral health care with a UPMC Health Plan Member's Primary Care Physician or other Provider, including behavioral health specialists.

Cultural competency

The understanding of the social, linguistic, ethnic and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into appropriate practices in the delivery of behavioral health services; assessment includes network providers' policies and readiness to address the cultural needs of Members.

E

Expedited Grievance

A request to change an adverse determination related to a request for medical care or treatment in which use of the timeframes for Pre-service Grievances

- (a) Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment or
- (b) Concerning admission, continued stay, or other behavioral health services for a member who received emergency services and has not been discharged from a facility and
- (c) That in opinion of a practitioner with knowledge of the member's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

F

Facility

An institution, organization or program licensed, or otherwise authorized, to provide health care services under applicable state or Federal laws or the laws of another appropriate jurisdiction including but not limited to freestanding psychiatric hospitals, psychiatric and addiction disorder treatment units in general hospitals, partial hospitalization programs, psychiatric and addiction disorder residential treatment centers, community mental health centers, ambulatory psychiatric and addiction disorder treatment Facilities and clinics.

Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

G

GAF (Global Assessment of Functioning):

A score on the most current version of the DSM Axis V.

H

HCFA (Health Care Financing Administration)

The former name of the Federal agency that regulates health care spending and provides Federal oversight for State health care spending agencies. This agency was renamed Center for Medicare and Medicaid Services (CMS).

HEDIS (Healthcare Effectiveness Data and Information Set)

One of the most widely used set of health care performance measures in the United States which was developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS measures are designed to collect, assess, report on, and improve the quality of health care.

HIPAA (Health Insurance Portability and Accountability Act)

A Federal law addressing the privacy and confidentiality of patient information.

J

JCAHO

Joint Commission on Accreditation of Healthcare Organizations.

L

Life threatening emergency

As a result of a mental illness or substance use disorder, there is reason to believe the member is, or may become, homicidal or suicidal or the member or member's victim may suffer a disabling or permanent physical injury as a result of the member's behavior or condition; the assessment that a life-threatening emergency exists is based upon statements or behavior, member self-report, clinical judgment, or information obtained objectively.

LOC (Level of care)

The particular setting that a member receives care such as inpatient hospitalization, partial hospitalization, or outpatient setting.

LOF (Level of functioning)

A general term used regarding the member's ability to perform particular functions such as daily living skills and employment. It is often measured by such scales as the DSM Global Assessment of Functioning (GAF).

LOS (Length of stay)

Continuous days of service for an admission to a Facility or program.

M

MBHO

Managed behavioral health care organization such as Community Care.

MCO

Managed care organizations such as a Physical Health managed care organization (like UPMC Health Plan) or a managed behavioral health care organization (like Community Care).

Medical necessity criteria

Written, objective criteria, based on sound scientific evidence, clinical principles and expert opinion used to determine the appropriateness of treatment interventions.

Member grievance

A request from a member, member representative, subscriber, or treating practitioner (who has written authorization from the member) for UPMC Health Plan to reconsider and change a decision, such as a Medical Necessity decision (See also Provider dispute).

Mihalik manual

The Mihalik Group manual, containing medical necessity criteria use for mental health treatment services.



N

NCQA

National Committee for Quality Assurance.

Non-life threatening emergency

As a result of a mental illness or substance use disorder, the member may suffer significant physical or emotional deterioration resulting in hospitalization or partial hospitalization unless an intervention is made within one hour.



P

PCP

Primary Care Physician.
Primary Care Provider.
Primary Care Practitioner.

PCPC (Pennsylvania Client Placement Criteria)

Medical necessity criteria set utilized by UPMC Health Plan for adult chemical dependency treatment services.

Peer Advisor

A licensed physician or doctoral-level behavioral health clinician, legally authorized to practice independently, who assists in making utilization management decisions; a peer advisor may only review care or service that he or she would be able to provide under the scope of his or her clinical license; denials of care or service based on clinical criteria (Medical Necessity Denials) may only be issued by peer advisors.

PH-MCO

Physical Health Managed Care Organization.

Post-Service review

Any review for care or services that have already been received; also known as a retrospective review.

Practitioner

A clinician licensed, certified, registered or otherwise legally authorized to practice independently by applicable state or federal regulation.

Provider

A term that encompasses both practitioners and facilities.

Provider Dispute

A request from a provider without the written authorization from the member to reconsider and change a decision (such as a Medical Necessity decision).



T

Td—Tetanus and Diphtheria vaccine

TEE—Transesophageal Echocardiography

TENS—Transcutaneous Electrical Nerve Stimulation

TMJ—Temporomandibular Joint Dysfunction



U

UB—Uniform Billing code

UPIN—Universal Provider Identification Number



V

VBA—Vision Benefits of America

VFC—Vaccines for Children

VZV—Varicella (chicken pox) vaccine