Appendix D: Terms to Know

Accrediting Body: An impartial external organization such as the National Committee for Quality Assurance (NCQA) and URAC that performs a comprehensive process in which a health care organization undergoes an examination of its systems, processes and performance to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards.

Adverse Determination: Any action by a health plan that denies or limits payment for the requested behavioral or medical treatment or services.

Appeal: A legal right for an insured individual, their provider or an authorized representative to seek relief against a health plan or third party determination to deny or limit payment for requested behavioral or medical treatment or services.

Appealing a Claim: The process to seek reversal of a denied behavioral health or medical claim. Most insurance carriers have their own process and timeline, but are subject to state and federal regulations.

Arbitration: An often binding process for the resolution of disputes outside of courts.

Balance Billing: The amount you could be responsible for (in addition to any co-payments, deductibles or coinsurance) if you use an out-of-network provider, which may represent the fee for a particular service that exceeds what the insurance plan allows as the charge for that service.

Behavioral Health: A descriptive phrase that covers the full range of mental health conditions and substance use disorders (MH/SUD).

Carrier: The insurance company that issues your insurance policy. The term is synonymous with health plan or health insurer.

Carve-Out: An independent managed behavioral health organization that manages the mental health and substance use disorder benefits separately from the plan's medical benefits.

Claim: A bill (or invoice), typically in a standardized form, containing a description of care provided, applicable billing codes and a request for payment, submitted by the provider to the patient's insurance company (or the plan's third party administrator).

Class Action: A lawsuit certified by a court that allows a number of plaintiffs to join in one lawsuit when they are suing a common defendant or defendants under common factual and legal grounds.

Classification: One of the six categories of benefits governed by MHPAEA (e.g., in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency room and prescription drugs).

Clinical Appeal: An appeal that involves a "medical-necessity determination" or other issue related to the medical appropriateness of care.

Clinical Practice Guideline: A utilization and quality management tool designed to help providers make

decisions about the most appropriate course of treatment for a particular patient.

Co-Payment: A dollar amount that an insured patient is expected to pay at the time of service.

Deductible: A dollar amount an insured patient must pay before the insurer will begin to make benefit payments.

Denial: Refusal of a request for payment or reimbursement of behavioral health or medical treatment services.

Denied Claim: Non-payment of a claim for reimbursement of behavioral health or medical services delivered to the insured patient. The insurance company must inform the patient of the non-payment of the claim and explain why the services are not being reimbursed.

Effective Date: The date your insurance coverage actually begins. You are not covered until the policy's effective date.

Employee Assistance Programs (EAPs): Mental health or substance use disorder treatment services that are sometimes offered by insurance companies or employers. Typically, individuals do not have to directly pay for services provided through an employee assistance program. EAPs are deemed to be part of an employer's single group plan for purposes of parity law application.

Employee Retirement Income Security Act (ERISA): A broad-reaching federal law that establishes the rights of health plan participants, requirements for the disclosure of health plan provisions and funding and standards for the investment of pension plan assets.

Exclusions: Specific conditions, services, treatments or treatment settings for which a health insurance plan will not provide coverage.

Explanation of Benefits: A statement sent from the health insurance company to an insured member listing services that were billed by a health care provider, how those charges were processed, the total amount paid and the total amount of patient responsibility for the claim.

External (Independent) Review: External review is part of the health insurance claims denial process. It typically occurs after all internal appeals have been exhausted, when a third party (that is intended to be independent from the plan) reviews your claim to determine whether the insurance company is responsible for paying the claim(s). External review is one of several steps that comprise the appeal and review process.

CAUTIONARY NOTE: Patients and providers should be cautioned that not all external appeals are reviewed by truly "independent" organizations. In self-funded ERISA cases, IROs are hired by the health plans or their agents that issued the denials the IROs are reviewing. Many IROs are also assigned by states to review denials made by the same organizations in fully-insured cases. Since external appeals are generally voluntary, consumers and their advocates should weigh the prospect that a health plan may attempt to rely on an external review denial to justify its internal denials when future care is sought or during any court case that may arise. This may limit or fully preclude any recovery or reimbursement on your claim. You may wish to consult with counsel to explore whether to proceed with an external review.

Fail First: Refers to a medical management protocol used by some health plans that requires that a patient demonstrate that they failed at a lower-cost therapy or treatment before the plan will authorize payment for a higher-cost intervention. Fail-first is considered a non-quantitative treatment limitation (NQTL) and must be comparable to and not applied more stringently to behavioral health benefits than as applied to

medical/surgical benefits. (Note: fail-first protocols used to deny coverage for entire levels of care under the behavioral health benefit have been found to violate the parity law, as they are not typically utilized for medical conditions, except in the prescription drug class of benefits.)

Financial Requirements: Includes deductibles, copayments, coinsurance and out-of-pocket maximums.

Formulary: A listing of drugs, classified by therapeutic category or disease class, that are considered preferred therapy for a given population and that are to be used by an MCO's providers in prescribing medications.

Fully Insured Plan: Employer-sponsored insurance plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs. These plans are regulated by state insurance commissions. The term is synonymous with "fully-funded plan."

Grandfathered Plans: Health Plans and other designated insurance arrangements that were in existence prior to March 23, 2010.

Grievance Appeal: A complaint by the insured related to a payment issue or the four corners of the benefit plan.

Health Insurance Portability and Accountability Act (HIPAA): A federal law that outlines the requirements that employer-sponsored group insurance plans, insurance companies and managed care organizations must satisfy in order to provide health insurance coverage in the individual and group health care markets.

Independent Review Organization: A third party organization that is intended to be unaffiliated with the health plan and to have no stake in the outcome of the review. Please refer to *CAUTIONARY NOTE* under definition for External (Independent) Review.

Inpatient: A term used to describe care rendered in a hospital or non-hospital based facility (e.g., inpatient detoxification, residential detoxification, inpatient rehabilitation, residential treatment, skilled nursing care, inpatient physical rehabilitation), as defined by the plan.

Managed Behavioral Health Organization (MBHO): An organization that provides behavioral health services by implementing managed care techniques.

Medicaid: A joint federal and state program that provides hospital, medical and behavioral coverage to the low-income population and certain aged and disabled individuals.

Medical/Surgical Benefits: For purposes of this reference guide, the phrase refers to insurance coverage for medical and surgical (non-behavioral health) services.

Medically Necessary: Health care services that are clinically indicated for the diagnosis and/or treatment of a medical or behavioral health condition.

Medical Necessity Appeal: An appeal filed when the health plan has denied payment or reimbursement for level of care or service based on a "lack of medically necessity". Synonymous with "UM appeal".

Medicare: A federal government program established under Title XVIII of the Social Security Act of 1965 to provide hospital expense and medical expense insurance to elderly and disabled persons.

Mental Health Condition and Substance Use Disorder (MH/SUD): The phrase used in the Mental Health Parity and Addiction Equity Act (MHPAEA), accompanying regulations and certain state laws to describe the range of behavioral health conditions.

National Committee for Quality Assurance (NCQA): One of several accrediting bodies that performs evaluations of health plan procedures and performance.

Network: The group of physicians, hospitals and other medical care professionals that a managed care plan has contracted with to deliver medical and/or behavioral health services to its members.

Non-Quantitative Treatment Limitation (NQTL): Any non-financial treatment limitation imposed by a health plan that limits the scope or duration of treatment (i.e. pre-authorization, medical necessity, utilization review, exclusions, etc.).

Out-of-Network: Physicians, hospitals, facilities and other health care providers that are not contracted with the plan or insurer to provide health care services at discounted rates. Depending on an individual's plan, expenses incurred by services provided by out-of-plan health care professionals may not be covered or may be only partially covered.

Outpatient Care: Treatment that is provided to a patient on a non-24 hour basis without an overnight stay in a hospital or other inpatient or residential facility.

Partial Hospitalization Services: Also referred to as "partial hospital days", this refers to outpatient services performed as an alternative to or step-down from inpatient mental health or substance use disorder treatment.

Pre-Authorization: Confirmation of coverage by the insurance company for a service or product before receiving the service or product from the medical provider. This is also known as prior authorization.

Provider Payment: The amount of money paid to the health care provider by the insurance company for services rendered.

Quantitative Treatment Limitation (QTL): Limits based on frequency of treatment, number of visits, days of coverage or days in a waiting period. A limitation that is expressed numerically, such as an annual limit of 50 outpatient visits.

Usual, Customary and Reasonable Fees (UCR): Often defined as the average fee charged by a particular type of health care practitioner within a geographic area for a particular type of service. These fees are sometimes used by insurers to determine the amount of coverage for health care services provided by out-of-network providers. The insured may be responsible for any copayment, coinsurance and deductible, as well as any remaining portion of the provider's fee that is not covered by the UCR fee.

Reason Codes: A letter or number system typically presented and defined at the bottom of an Explanation of Benefits (EOB) used to explain how the insurance claim was processed and why the insurance company denied all or part of your claim.

Self-Insured Plan (ERISA): A plan offered by employers who directly assume the major cost of health insurance for their employees. Self-insured employee health benefit plans are exempt from many state laws and instead are subject to federal (ERISA) law. Synonymous with self-funded plan.

Summary Plan Description (SPD): A description of the benefits included in your health plan.

URAC: One of several accrediting bodies that performs regular evaluations of health plans processes and performance. URAC, for example, has a specific standard for plan parity compliance.

Utilization Management (UM) Appeal: Synonymous with “medical necessity appeal”.