

## **GLOSSARY OF TERMS**

\* Represents definition from the Centers for Medicare & Medicaid Services

\*\* Represents definition from the American Psychiatric Glossary, 1994, American Psychiatric Press, Inc., Washington DC

### **Abuse or Inappropriate Billing**

Providers agree that in no event, including, but not limited to, nonpayment by ValueOptions or payer, insolvency of ValueOptions or payer or breach of the provider/facility agreement with ValueOptions, shall the provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, for health care services provided pursuant to this agreement.

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### **American Society of Addiction Medicine (ASAM)**

The nation's medical specialty society dedicated to educating physicians and improving the treatment of individuals suffering from alcoholism and other addiction (<http://www.asam.org/>).

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### **Balance Billing**

Providers agree that in no event, including, but not limited to, nonpayment by ValueOptions or payer, insolvency of ValueOptions or payer or breach of the provider/facility agreement with ValueOptions, shall the provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, for health care services provided pursuant to this agreement.

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### **Contracted Provider**

Any hospital, skilled nursing facility, extended care facility, individual, organization or licensed agency that has a contractual arrangement with an insurer for the provision of services under an insurance contract.

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### **Coordination of Benefits (COB)**

A provision which requires that when a Member is covered by two or more group health plans, payment will be divided between them so the combined coverage will pay up to 100% of eligible expenses; most group plans contain this provision. The claim is sent to the primary carrier first, and then their explanation of benefits is sent with the claim to the secondary carrier.

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### **Coordination of Care**

The process of coordinating care among behavioral health care providers and between behavioral health care providers and physical health care providers with the goal of improving overall quality of a Member's health care.

**Co-payment**

That portion of a charge for services that must be paid by a Member and is not covered by the Member's benefit program. Providers are not allowed to bill Members for charges not covered by the Member's benefit plan aside from any applicable copayments and deductibles.

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**Covered Employee**

An employed individual eligible to participate in an employer's health plan or EAP.

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**Covered Services**

Mental health and substance abuse services which are within the scope of the Member's benefit plan.

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**Deductible**

That portion of a charge for a covered service that must be paid by a Member before any insurance coverage applies.

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**Eligibility**

The determination that an individual meets the requirements to receive health care benefits as defined by the employer.

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**Emergency**

A psychiatric emergency exists when an individual with a defined DSM-IV-TR or ICD-9 diagnosis is in significant distress, is significantly dysfunctional and is in real and present danger to him/herself or others. An emergency also exists when there is an immediate and severe medical complication as a consequence of the psychiatric illness or its care. A psychiatric emergency requires immediate direct intervention by a licensed mental health professional who will accept responsibility for emergency evaluation and disposition. A psychiatric emergency does not necessarily require an Inpatient level of care but does require adequate security and medical support to evaluate and treat the psychiatric emergency without risk to the individual or others. (This is a general definition for reference purposes only. Please see your provider contract for the definition appropriate to your contract.)

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**Fraud**

Intentional perversion of truth in order to induce another to part with something of value or to surrender a legal right. An act of deceiving or misrepresenting. Abuse and Inappropriate billing could evolve into fraud.

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**Kansas Client Placement Criteria (KCPC) System**

KCPC refers to the standardized, computer-based assessment tool which gathers biopsychosocial information for a Member utilizing criteria established by ASAM for determining the level of treatment a Members needs.

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**Medicaid\***

A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

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**Member**

Any individual who is covered by the employer's benefit plan. May also be referred to as beneficiary, enrollee, participant (EAP only), or Member.

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**Mental Health or Substance Abuse Condition or Mental Disorder**

A nervous or mental condition that is:

- (i) A clinically significant behavioral or psychological syndrome or pattern;
  - (ii) Associated with
    - (a) A present distress or painful symptom;
    - (b) A disability or impairment in one or more important areas of functioning; or
    - (c) A significantly increased risk of suffering death, pain disability or an important loss or freedom; and
  - (iii) Is a condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV)
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**Participating Provider or Provider**

A participating provider is a practitioner, group practice, program or facility whose credentials, including, but not limited to, degree, licensure, certifications and specialists, have been reviewed and found acceptable by ValueOptions to render services to ValueOptions' Members and agrees to accept the plan's pre-established fee, or reasonable charge, as the maximum amount which can be collected for the service rendered.

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**Prepaid Health Plan\***

A prepaid managed care entity that provides less than comprehensive services on an at risk basis or one that provides any benefit package on a non-risk basis.

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**Social Security Act\***

Public Law 74-271, enacted on August 14, 1935, with subsequent amendments. The Social Security Act consists of 20 titles, four of which have been repealed. The HI and SMI programs are authorized by Title XVIII of the Social Security Act.

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**Substance Abuse\*\***

Impairment in social and occupational functioning resulting from the pathological and "compulsive" use of a substance. The concept is closely related to the definition of substance dependence, which has similar symptoms of impairment but may include evidence of physiological tolerance or withdrawal. Typical symptoms include failure to fulfill major role obligations at work, school or home; recurrent use of the substance in situations where such use is physically hazardous; substance-related legal problems and continued use even though it causes or exaggerates interpersonal problems.

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**Utilization Management (UM)**

The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria. Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM usually includes new actions or decisions based on the overall analysis of the utilization.