

VOC GLOSSARY OF TERMS

Accessibility

The extent to which members have access to medically necessary services. This may include the number and geographic distribution of providers, number and types of specialists, number and geographic distribution of hospitals, emergency services, and ancillary facilities, or any other barriers to obtaining care. (See Availability)

Acute Condition

A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Administrative Services Only (ASO)

An account for which on behalf of *ValueOptions, Inc.*, VOC provides only administrative services, such as network referrals and utilization review. The employer, health plan or government agency is at risk for the health care costs.

Adverse Incidents

Occurrences that represent actual or potential serious harm to the well being of a VOC member, or to others by a VOC member who is in active behavioral health treatment/EAP services, or has been recently discharged (i.e. within the past 6 months) from behavioral health treatment/EAP services. Adverse Incidents must be reported to VOC.

American National Standards Institute (ANSI)

ANSI is a private, non-profit organization (501(c)3) that administers and coordinates the U.S. voluntary standardization and conformity assessment system. www.ansi.org

Americans With Disabilities Act (ADA)

A 1992 federal civil rights statute which prohibits discrimination against disabled individuals in the areas of employment, public accommodations and commercial facilities, state and local government services, transportation programs, activities and telecommunications.

Appeal

A formal request by a provider or member for reconsideration of a decision to deny, modify, or delay health care services, with the goal of finding a mutually acceptable solution. This may include utilization review recommendations, benefit determinations, administrative policies, quality-of-care or quality of service issues. (See Grievance)

Assignment of benefits

Authorization by the member for *VOC* to pay benefits directly to the medical care provider. In Medicare, if a physician accepts assignment from the patient, he must agree to accept the program as payment in full (except for specific coinsurance, copayment and deductible amounts required of the patient).

Authorization

Approval for a specific covered service to be delivered to a covered member. An authorization represents agreement that the service is clinically necessary under *VOC* clinical care criteria.

Automated Benefits Advisory

Member benefits information is available 24 hours per day through the Automated Benefits Advisory. Call to verify coverage for outpatient services and to obtain certification guidelines.

Availability

The extent to which members can obtain medically necessary services at the time they are needed. This may include telephone availability, appointment availability, office hours, office waiting times, or any other barriers to obtaining timely care. (See Accessibility)

Balance Billing

The practice of charging full fees in excess of reimbursable amounts, then billing the patient for that portion of the bill not covered. This practice is not allowed by *VOC*.

Back to Work Conference*

A meeting designated to facilitate the return to work of an employee who was on leave for the purposes of receiving treatment.

Center for Medicare and Medicaid Services Form (CMS 1500)

Standard outpatient billing form for providers. Formerly known as HCFA 1500.

Certification, Certifies or Certified

Mean the decision of *VOC* resulting from the case management process to determine whether proposed or rendered treatment is Medically Necessary.

Certified Employee Assistance Professional (CEAP)

A voluntary designation obtained through examination indicating the bearer has demonstrated a mastery of the fundamental body of knowledge required to perform Employee Assistance Program functions.

Chain of Custody*

A detailed protocol for the tracking, handling and storage of breath, urine or blood specimens obtained by drug or alcohol testing.

Claim

A request for reimbursement under a benefit plan for health care services. The claim may be initiated by the member or by a treating provider.

Clinical Advisory Committee

A panel of providers in a given locality who meet periodically to advise *ValueOptions* on matters of clinical policy and quality improvement.

Clinical Appeal

An oral or written request seeking reconsideration of a prior clinical decision, which may be submitted by a member. A Clinical Appeal is considered to be a specific type of Grievance.

Commission on Accreditation of Rehabilitation Facilities (CARF)

A private, not-for-profit organization that accredits programs and services (adult day services, assisted living, behavioral health, employment and community services, and medical rehabilitation). CARF develops and maintains practical and relevant standards of quality for such programs.

Compliance*

An EAP participant's adherence to a plan that is mutually established with an EAP professional for resolving the EAP participant's personal problems.

Concurrent Review

Determining medical necessity for care by case review while the patient is in treatment.

Constructive Confrontation*

A meeting between an employee, supervisor and if appropriate, union representative, to discuss deficiencies in the employee's job performance in order to motivate the employee to change behavior, improve job performance and prevent future disciplinary action.

Continuous Quality Improvement

VOC has a comprehensive Quality Improvement program. VOC expects and appreciates your participation in quality improvement activities as requested. Your performance as a provider may be reviewed in a variety of ways, including:

- member satisfaction surveys
- member outcome surveys
- care manager reports
- tracking of member complaints
- site visits/treatment record reviews

VOC quality improvement staff will contact you if concerns arise regarding performance and you may be subsequently asked to participate in a performance improvement plan.

Contract Effective Date

The date the provider, group or facility joins the VOC health care system as an in-network provider.

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.

Counseling

Services provided to a Member by an EAP Affiliate where when indicated by an Assessment, the EAP Affiliate assists the Member with the resolution of a Problem that typically can be resolved in a series of face to face sessions over a short period of time.

Coverage Decision

A *VOC* decision to approve or deny mental health and substance abuse care services substantially based on a finding that the provision of a particular service is included or excluded as a Covered Service under the terms and conditions of the Member's *VOC* Plan. A Coverage Decision does not encompass a *VOC* decision regarding a Disputed Behavioral Health Care Service.

Covered EAP Services

Those services provided to EAP Members in accordance with the professional and technical EAP standards adopted by *VOC* and covered under the terms of a specific Client's EAP.

Covered Employee

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

Covered Services

Those mental health and/or substance abuse services for treatment of a Mental Health or Substance Abuse Condition or Mental Disorder which are Medically Necessary and to which Members are entitled to receive pursuant to the applicable *VOC* Plan.

Credentialing

The review process to determine if a provider, group, program or facility that has applied to participate in the *VOC* provider network meets criteria for inclusion.

Credentialing Committee (CC)

A *VOC* internal committee that functions as a peer review body under NCQA standards. The CC is made up of representatives of all major clinical disciplines and includes network providers. The committee is tasked with making the final decision on *VOC* credentialing policies and procedures; approval, denial and pending status for all applications to join the network; and making decisions on possible provider sanctions.

Crisis Intervention*

A rapid, intensive helping process that includes engaging the individual, assessment, building EAP participant support, contracting, follow-up and possibly referral to longer-term treatment.

Critical Incident

A patient's death, escape or serious injury requiring emergency treatment when it occurs during the course of an inpatient admission.

Critical Incident Debriefing (CID)*

A structured intervention that encourages the expression of thoughts and feelings about the incident followed by identification and normalization of symptoms, familiarization with the process of recovery and referral to appropriate services.

Cultural Competence

The capacity of the network to address behavioral health needs of members in a manner that is congruent with their cultural, religious, ethnic and linguistic backgrounds.

Current Procedural Technology (CPT)

A descriptive number from the Physicians' Current Procedural Terminology, a nationally accepted listing of terms and identifying codes for reporting medical services and procedures.

Diagnosis (Dx)

A classification for mental health disorders and substance related disorders, which may be defined on as many as five axes. *VOC* uses the *Diagnostic and Statistical Manual of Mental Disorders, DSM-IV* of the American Psychiatric Association as its standard. The ICD-9CM is an international version, which includes both medical and mental health diagnoses.

Disciplinary Process*

A process based on organizational policies and procedures in which an employee is progressively disciplined for inadequate job performance or inappropriate work behavior.

Disenrollment

The termination of a provider, group practice, program or facility as a *ValueOptions* participating provider. Disenrollment may be initiated by *ValueOptions* or the participating provider, with or without cause, in accordance with contract terms.

Disputed Behavioral HealthCare Service

Any mental health or substance abuse care service eligible for coverage and payment under a member's *VOC* Plan that has been denied, modified, or delayed by *VOC* in whole or in part due to a finding that the service is not Medically Necessary. A decision regarding a Disputed Behavioral Health Care Service is not a Coverage Decision.

Drug Test*

A method of detecting and measuring the presence of alcohol and/or illegal drugs in a person's body.

Drug-Free Workplace Act*

Requires private employers with federal contracts worth \$25,000 or more to take action against employees prosecuted for illegal drug offenses at the workplace. The employer is also required to establish company drug policies and maintain a drug-free environment through employee prevention education and assistance.

DSM-IV "V" Code

The DSM-IV classification of other conditions that may be a focus of clinical attention. Examples include partner relational problem, occupational problem or academic problem.

Dual Diagnosis

Used to describe an individual who has co-occurring psychiatric and substance use disorder diagnoses, developmental disorders and/or medical diagnoses.

Duplicate Claim

A claim with the same member number, date of service, provider and service/procedure as a previously paid claim.

Duty to Protect

A clinician's obligation to protect an intended victim of any potential harm as expressed by a client.

Duty to Warn

A clinician's obligation to alert an intended victim of any potential harm as expressed by a client.

EAP Affiliate

A provider who has met *VOC* credentialing criteria for EAP affiliates and has entered into a currently effective agreement with *VOC* as an independent contractor to provide EAP services to EAP participants.

EAP Assessment*

A structured evaluation process performed to identify, define, and triage a Member's personal Problem(s) and concerns

EAP Case*

A formal, documented relationship between an employee assistance professional and participant or eligible dependent that is initiated upon provision of an assessment and/or counseling. More than a casual conversation or informational call, the case entails the opening of a file; awareness by the participant, covered employee or eligible dependent that he/she represents an EAP case; keeping case notes of the discussion(s) and reporting problem disposition. A case may also be opened when an EAP participant requests follow-up services from the employee assistance professional. Casual conversation in person or by phone where not all of the above occurs is not considered a case. Contact with others such as worksite supervisors who are not seeking personal assistance is not counted as a case.

EAP Case Management*

The provision of EAP services following EAP participant referral to external community organizations and resources for care that may include facilitating, coordination, monitoring and discharge planning.

EAP Communication Plan

An annual plan designed to maximize the visibility and workplace acceptance of the EAP. The plan is individualized for each EAP contract and is fully integrated with the payer's internal communication system.

EAP Design*

The structural, logistical and financial elements necessary for successful EAP operations.

EAP Feedback Mechanism*

Methods of receiving information about employee assistance services from EAP participants. One method used is to have supervisors complete a survey measuring employee job performance after contact with the EAP.

EAP Follow-Up*

One or more contacts with an EAP participant to monitor progress and/or the impact of the EAP recommendations or referrals to treatment resources and to determine the need for additional services.

EAP Participant Satisfaction*

A measure of EAP performance based on formal or informal feedback from EAP participants. Feedback may be given to the medical or human resources department or directly to the EAP. Objective measurement of client satisfaction is obtained from anonymous response surveys that are distributed as standard operating procedure upon closure of a case.

EAP Member

An Employee and the eligible Family Members of an Employee enrolled in an EAP program administered by *VOC*.

EAP Plan

Any EAP sponsored by a payer that has entered into a contract or other agreement with *ValueOptions* to arrange for the provision of certain EAP services.

EAP Referral*

The process of linking EAP participants with appropriate resources to resolve personal Problems or concerns.

EAP Self-referral

A covered employee or eligible dependent initiating the request for EAP service.

EAP Short-term Problem Resolution*

The process of assisting (when indicated by assessment) an individual or family with the resolution of a problem in a period of time which typically does not exceed two months.

EAP Supervisor/Union Training*

A formal training session for supervisors, managers and labor representatives (if a unionized work setting) to familiarize them with EAP activities.

EAP Supervisory Referral*

An action in which an employee having job-performance problems is referred to the EAP by the employee's worksite personnel.

EAP Utilization Rate*

The percentage derived from the number of active EAP cases divided by the total number of employees over the course of a year. If the reporting period is less than a year, the utilization rate is annualized.

EDI: Electronic Data Interchange

The exchange of information between two systems in an electronic format

Eligibility

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

Emergency Medical or Behavioral Condition

A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the persons or others in serious jeopardy; or (2) serious impairment to such person's bodily functions; or (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

Emergency Services or Emergency Care

Medically Necessary ambulance and ambulance transport services provided through the 911 emergency response system and those Covered Services provided for screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency

medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

Employee Assistance Professional Ethics

A code of conduct requiring the placing of EAP participants' interest above self-interests. Rules of conduct include proper workplace communication and interaction, service delivery without conflict of interest, proper ongoing interaction in the community, proper professional interactions and continued proficiency as an EAP professional.

Employee Assistance Program(EAP)*

A worksite-based program designed to benefit covered employees and their dependents in the identification and resolution of personal problems or concerns that may adversely affect job performance.

Employee Orientation*

A meeting to acquaint employees with assistance services offered by the employer.

Employment Retirement Income Security Act (ERISA) of 1974

Federal law mandating reporting and disclosure requirements for group life and health plans.

Encounter

A face-to-face meeting between a covered person and a health care provider where services are delivered.

Equal Employment Opportunity*

Title VII of the Civil Rights Act of 1964, as amended by the Civil Rights Act of 1991, prohibiting discrimination on the basis of race, color, religion, sex or national origin by employers (both public and private) engaged in industry affecting commerce and that have fifteen or more employees.

Electronic Transport Server (ETS)

The *ValueOptions* online service that enables users to upload files from their PCs

Expedited or Urgent Grievance

A grievance requiring expedited review because it involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function. Expedited grievance requests could involve a matter of dissatisfaction and clinical issues prior to an initial determination and/or as an appeal to an adverse determination. As they are clinical issues, expedited requests are reviewed and resolved through the clinical review process.

Explanation of Benefits (EOB)

A statement mailed to providers explaining why a claim was or was not paid.

Fee for Service

A form of reimbursement for health services in which a provider is paid a specific amount for a service rendered.

Global Assessment of Functioning (GAF)

A rating scale utilized to report an individual's overall functioning on Axis V of the DSM-IV diagnostic scheme.

Grievance

A written or oral expression of dissatisfaction regarding *VOC* and/or a provider, including quality of care concerns, and includes a complaint, dispute, request for reconsideration, or appeal made by a member or the member's representative.

Health Care Financing Administration (HCFA)

Standard outpatient billing form for providers. Now known as CMS - Centers for Medicare and Medicaid Services. www.cms.hhs.gov/default.asp?

Health Care Financing Administration (HCFA) - now called CMS (Center for Medicare and Medicaid Services):

Department of the federal government responsible for Medicare and Medicaid policy and administration. HCFA is also responsible for implementing various unrelated provisions of HIPAA.

Hold Harmless

A requirement specifying that a participating provider is contractually responsible to hold the

member harmless and not seek reimbursement from the member, other than co-payments, for any changes incurred for service rendered, until after the entire provider appeals process is completed.

Independent Medical Review (IMR)

The IMR process is a remedy that exists in addition to the other procedures and remedies afforded to the member through grievance/appeal procedures elsewhere in *VOCPolicies and Procedures*. The IMR is a process of dispute resolution conducted by a medical specialist(s) who will make an independent determination of whether or not the care in question is medically necessary. The IMR process is coordinated through the Department of Managed Health Care (“DMHC”) and its’ contractual arrangements with one or more IMR organizations

Individually Identifiable

Means the Medical Information which includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

Joint Commission on Accreditation of HealthCare Organization (JCAHO):

An independent not-for-profit organization dedicated to improving the quality of care in organized health care settings. The major functions of the Joint Commission include developing organizational standards, awarding accreditation decision and providing education and consultation to health care organizations.

Last-chance Agreement*

A signed agreement between an employee whose job is in jeopardy and supervisor or other representative of management. The agreement specifies the performance expectations and other conditions of employment and can require compliance with EAP recommendations.

Length of Stay

The number of days that a member remains in a given level of care.

Level of Care

The intensity of professional care required to achieve the treatment objectives for a specific episode of care.

Lifetime Maximum

The maximum amounts that *VOC* will pay to cover a member's care during his/her lifetime.

Medical Information

Means any Individually Identifiable information, in electronic or physical form, in possession of or derived from a provider, pharmaceutical company, *VOC*, or a contractor regarding a patient's medical history, mental or physical condition, or treatment

Medical Review Officer*

A licensed physician knowledgeable of substance abuse disorders and trained in interpretation and evaluation of positive test results who is responsible for analyzing laboratory results generated by an employer's drug testing program.

Medically Necessary means those services or supplies for the treatment of an active Mental Disorder or Substance Abuse Condition which, consistent with professionally recognized standards of practice, are determined by the *VOC* Medical Director or designee to be:

- 1) Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), that threatens life, causes pain or suffering, or results in illness or infirmity.
 - 2) Expected to improve an individual's condition or level of functioning.
 - 3) Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
 - 4) Consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
 - 5) Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available.
 - 6) Not primarily intended for the convenience of the recipient, caretaker, or provider.
 - 7) No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
 - 8) Not a substitute for non-treatment services provided for the enrichment of a patient's environment such as the provision of custodial or housing services that may otherwise enhance patient wellness.
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Medication Management Registration Form

In Service Centers/contracts without IVR capability, physicians register outpatient medication

management services with *ValueOptions* by completing and sending/faxing a Medication Management Registration Form to the appropriate Service Center.

Member

Any individual who is covered by the employer's benefit plan.

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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National Committee on Quality Assurance (NCQA)

In January 1997, NCQA established accreditation standards for managed behavioral healthcare organizations (MBHO). Many *ValueOptions* policies, procedures and quality initiatives are driven or influenced by NCQA standards. Some of the quality indicators established by the NCQA are:

- scheduling standards that establish accessibility timeframes
 - conducting site visits and treatment record reviews
 - credentialing and recredentialing requirements
 - developing preventative healthcare programs
 - conducting member satisfaction surveys
 - implementing confidentiality procedures
 - reporting serious provider quality deficiencies to appropriate authorities
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National Practitioner Database (NPDB)

A federally mandated agency, which is the repository of information about settled malpractice suits and adverse acts, sanctions or restrictions against the practice privileges of a physician.

Negative Balance

The dollar amount over-paid for services rendered.

Newborn Child

A newborn child between birth and age 36 months.

Non-Certification

In those cases in which the provider has not demonstrated medical necessity for proposed or continuing services at a particular level of care, a non-certification decision is rendered by *VOC*.

Non-Compliant

Failure of an EAP participant to commit to the goals or procedures prescribed in the treatment plan.

Non-participating Provider

A provider, group practice, program or facility that is not contracted as participating in the *VOC* network.

Out of Pocket Expense:

The sum of patient copayments for a claim.

Out of Pocket Maximum:

The maximum amount an individual pays, through co-payments for mental health and substance abuse care in one benefit year.

Outcome Goals

Expected results related to employee assistance service delivery.

Outpatient Psychological Testing Report (OPTR)

A *ValueOptions* form used to preauthorize outpatient psychological testing.

Outpatient Treatment Record (OTR)

A *ValueOptions* form used to review outpatient mental health and/or substance abuse treatment. Used for the certification of medically necessary services based on *VOC* requirements.

Participating Provider

A health care provider that has entered into an agreement accepted by *VOC* to provide Covered Services to Members. Participating Providers include without limitation psychologists, psychiatrists, clinical social workers, marriage and family therapists, registered nurse clinical specialists, hospitals and other facilities licensed to provide Covered Services within the Service Area.

Pass-through Visit

An outpatient visit that does not require treatment authorization. The number of pass-through visits that can occur before registering care varies by contract.

Peer Advisor

A *VOC* licensed psychiatrist, licensed psychologist or master's-level licensed professional who provides peer reviews and clinical consultations on cases.

Per Problem

Each separate incident, event, or situation which causes a Member to seek EAP services and for which a different diagnosis and/or treatment plan is provided.

Pre-certification Review

A review that is conducted prior to an actual admission to determine medical necessity for the requested level of care. This review can result in an admission, averted admission, or a non-certification.

Primary Assessed Problem*

The problem assessed by the EAP counselor as the core-underlying problem causing other problems when multiple concerns are presented. The primary problem is one that must be addressed before secondary problems can be effectively resolved.

Problem

A concern or event for which an EAP Member is seeking Assessment, Referral or Counseling Services.

Problem Resolution*

In self-referrals, problem resolution is the EAP participant's achievement of personal goals developed in conjunction with the EAP professional. In management/supervisor referrals, it is an employee's return to his/her previous level of satisfactory job performance or termination following continued unsatisfactory job performance.

Professional Development Hours (PDHs)*

The unit measurement for CEAP continuing education and a means by which the CEAP certification is maintained.

Provider ID

The ID that *ValueOptions* uses to uniquely identify the provider or clinic or group, etc. Contact your local *ValueOptions* Provider Relations representative to obtain your Provider ID.

Psychiatric Conditions

Conditions or diseases that involve mental, emotional or behavioral disorders.

Quality Assurance/Improvement

A structured system for continually assessing and improving the overall quality of service delivered to members.

Recredentialing

The review process to determine if a provider continues to meet the criteria for inclusion as a participating *VOC* EAP affiliate or participating provider.

Reduction in Force*

The process by which a work organization reduces its work force by eliminating jobs, such as closing subsidiaries or departments. Also called downsizing.

Reentry/Reintegration

The process of helping an employee, who was on leave, to receive behavioral health treatment, restore relationships in the workplace and reestablish a satisfactory level of job performance.

Release of Information

The legal form signed by an EAP participant or member allowing *VOC* to share specific information regarding the EAP participant or member with a specific person.

Requests for Additional Information

To maintain your network status, you must furnish *ValueOptions* with any requested documentation or information promptly. Failure to do so may result in your status being changed from active to inactive. Inactive providers are ineligible to receive referrals or reimbursement as participating providers for services rendered to members of *ValueOptions*' client accounts.

Retrospective Review

The process of determining necessity for care by case review after treatment has been completed.

Risk Management*

A strategy for minimizing a work organization's exposure to health and safety factors that pose a threat of loss to the organization.

Safety-Sensitive Position*

A work assignment that entails high safety risk to self, property or general public and is with an industry that is subject to federal regulations requiring compliance with safety regulations.

Serious Chronic Condition

A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Serious Emotional Disturbances of Child

A Serious Emotional Disturbance (“SED”) of a child is defined as a child who:

- (i) Has one or more Mental Disorders as defined by the Diagnostic and Statistical Manual (DSM-IV), other than a primary substance use disorder or developmental

disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and

(ii) Is under the age of eighteen (18) years old.

(iii) Furthermore, the child must meet one or more of the following criteria:

- a. As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - (i) the child is at risk of removal from home or has already been removed from the home,
 - (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment, or
- b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder, or
- c. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

Service Area

The geographical area in which *VOC* is licensed to operate pursuant to the Knox-Keene Act.

Severe Mental Illness

Severe Mental Illness (“SMI”) includes the diagnosis and Medically Necessary treatment of the following conditions:

Anorexia Nervosa
Bipolar Disorder
Bulimia Nervosa
Major Depressive Disorder
Obsessive-Compulsive Disorder
Panic Disorder
Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.
Schizoaffective Disorder
Schizophrenia

Sexual Harassment

As specified in Title VII of the 1964 Civil Rights Acts, amended in 1972, sexual harassment can be unwelcome sexual advances, requests for sexual favors or other verbal or physical conduct of a sexual nature.

Single Fixed Point of Accountability (SFPA)

A provider or agency that coordinates services to enable a child/adolescent to live in the least restrictive environment possible and increase adaptive capabilities.

Site Visits/Treatment Record Review

As part of provider selection and quality monitoring, site visits and treatment record reviews will be conducted on selected providers as part of the credentialing and recredentialing process. *ValueOptions* has developed site visit and treatment record review criteria based on *ValueOptions* standards and the requirements of the National Committee for Quality Assurance (NCQA).

Special Circumstances

Refers to an Acute Condition, Serious Chronic Condition, Newborn Care, or Surgery/Other Procedure.

Stabilization

That in the opinion of the treating provider, consistent with professionally recognized standards of practice, the Member's Emergency Medical or Behavioral Condition is such that, within reasonable medical probability, no material deterioration of the Member's condition is likely to result from, or occur during, a transfer of the patient.

Submitter

Entity (provider, billing agent or clearinghouse) responsible for submission of claims to *ValueOptions* for adjudication

Submitter ID

The ID that *ValueOptions* assigns to uniquely identify the entity that is sending in electronic files, for one provider or multiple providers. Normally, we will use the Provider ID provided on the EDI electronic claims application and designate it as your Submitter ID.

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.

Surcharge

An additional fee charged to a Member for a Covered Service.

Surgery/Other Procedure

Refers to a surgical or other procedure that is authorized by *VOC* as part of a documented course of treatment which has been recommended and documented by a “provider,” as defined at Section 1345(i) of the California Health and Safety Code, to occur within one hundred eighty (180) days of the termination, nonrenewal or expiration of the Agreement between *VOC* and Provider.

Terminated Provider

A provider whose contract with *VOC* is terminated, expires, or is not renewed.

Topical Seminar

Seminars are typically one hour in length and may be customized to cover unique topics of concern to a payer's employees.

Utilization Review Accreditation Commission (URAC)

URAC, also known as the American Accreditation HealthCare Commission, is a non-profit charitable organization founded in 1990 to establish standards for the health care industry. URAC's first mission was to improve the quality and accountability of health care organizations using UR programs. In later years, URAC's mission expanded to cover a larger range of service functions found in various health care settings including the accreditation of integrated systems such as health plans to smaller organizations offering specialty services. Now, in its 12th year of operation, URAC has a total of 13 accreditation programs.

Urgently Needed Services

Those services required to prevent serious deterioration of a member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the member returns to *VOC* service area.

W-9 Form

A document used by the IRS to validate a tax ID (either SSN or EIN) and the person or entity it represents. A valid W-9 Form is required for each pay-to vendor.

Worker's Compensation*

A means of insurance providing medical rehabilitation and wage replacement benefits to employees after an injury or the onset of disease arising out of and in the course of employment.

* EAP definitions adopted from EAPA glossary, Arlington, Virginia 1994

** Definition from the American Psychiatric Glossary, 1994, American Psychiatric Press, Inc., Washington DC