



## Glossary of Terms

**Abuse:** Payment for those items or services, where no legal entitlement exists and for which the health care provider has not knowingly or intentionally misrepresented the facts to receive payment.

**Acute Partial Hospitalization:** Acute partial hospitalization is a hospital-based program designed for the treatment of clients with acute psychiatric illness, or clients who are chronically ill and marginally functional and who require a more intensive and supervised treatment program than that which is afforded by various types of outpatient or aftercare programs. It provides an array of intensive psychiatric, medical, behavioral and developmental services to address the needs of individuals with acute psychiatric symptoms and reduced functionality who do not require hospitalization.

**Addendum:** Additions or changes to an already completed, full and comprehensive evaluation, based on either the exchange of clinical information or a face-to-face meeting with the client.

**Adjudication:** The process of reviewing and editing claims to determine whether services were performed in accordance with government regulations, insurance company policies and contractual agreements with the provider.

**Affiliated Provider:** A health care provider or facility that is part of the Managed Care Organization's network, usually having formal arrangements to provide services to the MCO's member.

**Assessment:** The preliminary compilation of biopsychosocial information, derived by interviewing a client and family members or caretakers, and reviewing past clinical records, to determine level of care placement.

**Behavioral Health Care Company:** (see Managed Care Organization).

**Behavioral Health Care Services:** Mental health and substance abuse treatment services.

**Behavioral Health Rehabilitation Services (BHRS):** The coordination of delivery of services to children and their families that is individually tailored to each case with the goal of keeping the family together in the community and being included in normalized school settings. BHRS was formerly called EPSDT.

**Care Management:** The managed care organizational function with the responsibility to authorize and coordinate the provision of in-plan services.

**Case Management:** The process by which all health-related matters of a case are managed by a designated health professional, who assist clients to obtain and coordinate community resources such as income assistance, education, housing, medical care, treatment, vocational preparation, and recreation. Case management is intended to ensure continuity of services and overcome fragmentation within service systems. It also attempts to match the appropriate intensity of services with the patient's needs over time.

**Capitation:** A dollar amount established to cover the cost of health care services delivered for a person during a specified length of time. The term usually refers to a negotiated per person rate that is paid periodically to a health care provider by a MCO. The provider is then responsible for delivering or arranging for all of the health services required by the enrolled person under the provider's contract.

**Carve-Outs:** A payer strategy in which a payer separates ("carves-out") a portion of the benefit and hires an MCO to provide these benefits. Many HMOs and insurance companies adopt this strategy because they do not have in-house expertise related to the service "carved out."

**CBH Provider Number:** The CBH provider number is the number assigned to each provider by the CBH IS system. A provider will have an assigned CBH provider number for each provider type and location it contracts with CBH to provide. CBH provider numbers are used in the authorization process.

**Centers for Medicare & Medicaid Services (CMS):** The agency within the Department of Health and Human Services which administers federal health financing and related regulatory programs, principally the Medicare, Medicaid, and Peer Review Organization.

**Clean Claim:** A claim that can be processed without requiring additional information from the provider or the Third-Party Payor.

**Clean Rejected Claim:** A claim that is returned to the provider or Third-Party Payor due to ineligible recipient or service.

**CMS 1500 Claim Form:** The Center for Medicaid and Medicare's standard form for submitting outpatient service claims to insurance companies.

**CODAAP:** Coordinating Office for Drug and Alcohol Abuse Programs, a component of the Philadelphia's Department of Behavioral Health.

**Complaint:** An issue, dispute or objection presented by or on behalf of a member regarding a participating health care provider, or the coverage, operations or management policies of a managed care plan.

**Community Support Services:** Community Support Services are a range of services designed to assist adults and children to function in the community. Services include: Intensive Case Management, Resource Coordination, Family-Based Mental Health Services and Crisis Residences.

**Concurrent Review:** A review process conducted after admittance to a level of care and prior to the expiration of the current authorized length of stay.

**Coordination of Benefits:** The process by which the cost for a covered service provided to a member in the event of an incident of sickness may be recovered from a member's primary insurer.

**Coordination of Care:** The process by which a member's care is coordinated to assist in the diagnosis and treatment of the member's psychiatric condition through consultations and exchange of pertinent information and events between the member's PCP and Behavioral Health Provider.

**Co-payment:** The portion of health care costs that the covered individual is expected to pay. Providers are specifically prohibited from charging co-payments to Medicaid recipients.

**Consumer Satisfaction Team:** In Philadelphia, the Consumer Satisfaction Team (CST) is an organization staffed by consumers and family members of consumers of mental health and substance abuse treatment services. The CST conducts visits to service sites year-round to ascertain consumer satisfaction with mental health and substance abuse treatment services in an effort to assure continued satisfaction with these services. Unlike organizations which solicit information through written questionnaires, the CST meets with consumers face to face to ensure that consumers have a voice in the choice and quality of their service. The CST meets regularly with staff from the Department of Behavioral Health to resolve consumer concerns.

**Credentialing:** A mechanism by which an MCO ensures that the treatment received by members is of high quality and that it is delivered by well-qualified professionals.

**Cultural Competence:** An awareness and acceptance of cultural differences, an awareness of one's own cultural values, an understanding of the "dynamics of difference" in the helping process, basic knowledge about the client's culture, and the ability to adapt practice skills to fit the client's cultural context.

**Crisis Residences (CR):** Crisis Residences provide short-term residential options in a community setting to persons in crisis, to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Clients may be provided 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.

**Delegated Credentialing:** In its Delegated Credentialing process, CBH offers providers established guidelines on which to base their own Credentialing Program. Subsequently, CBH reviews a provider's Credentialing Program and evaluates adherence to their program.

**Disenrollment:** The process of removing members from eligibility in Medicaid. Disenrollment of members lies within the sole authority of the Pennsylvania Department of Public Welfare.

**Drug & Alcohol (D&A) Addictions Professional:** A nationally accredited addictions practitioner, or a person possessing a minimum of a bachelor's degree in social science and two years experience in treatment/case management services for persons with substance abuse/addiction disorders.

**Dual Diagnosis.** A diagnosis of an emotional disorder and another disorder such as drug and alcohol abuse, developmental disability or a mental illness.

**Eligibility:** Member eligibility for behavioral health services under the HealthChoices Program is determined solely by the PA Department of Public Welfare.

**Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of severity (including 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: a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part.

**Emergency Services:** Covered inpatient and outpatient services that are furnished by a provider qualified to furnish such services under the Medical Assistance Program and are needed to evaluate or stabilize an emergency medical condition.

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT):** EPSDT program covers screening and diagnostic services to determine physical or mental problems in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.

**Evaluation:** The comprehensive gathering of biopsychosocial information through client interview, discussion with family members or caretakers, review of clinical records, and contact with collaborating agencies that leads to biopsychosocial formulation, diagnoses, and a biopsychosocial treatment plan.

**Explanation of Benefits (EOB):** A summary of benefits provided to subscribers or treatment providers by the insurance carrier.

**Family-Based Mental Health Services (FBMHS):** The Family-Based Mental Health Program provides short-term treatment services to children and adolescents and their families with mental health and/or substance abuse disorders. The program provides a variety of services to families in their home, including traditional therapy services and non-traditional services such as respite services for families, transportation and linkage with other service systems and community resources. The program services children who are at risk for psychiatric hospitalization, or placement out of the home.

**Federal Medicaid Managed Care Waiver Program:** The process used by states to receive permission to implement managed care programs for their Medicaid or other categorically eligible beneficiaries. This refers to the waiver of certain sections of the Social Security Act, Title XIX which requires states that pay for Medicaid on a fee-for-service basis to assure that all recipients of health care services have comparable services made available on a state-wide basis and that persons have freedom of choice of providers. Such waiver is required to provide Medicaid funded services in a prepaid managed care program in a cost effective manner.

**Federally Qualified Health Center (FQHC):** A center receiving a grant under the Public Service Act or an entity receiving funds through a grantee of the Act. These include community health centers, migrant health centers and health care for the homeless population. FQHC services are mandated Medicaid services, health education, and mental health services.

**Fee-For-Service:** A payment system by which doctors, hospitals and other providers are paid a specific amount for each service performed. This is considered the traditional form of health insurance.

**Fraud:** Intentional deception or misrepresentation that is made by an individual who knows it to be false and who receives an unauthorized benefit from the action.

**Freestanding Facility:** Usually refers to an autonomous treatment service that is not connected with a hospital or to other services (e.g., a freestanding detoxification unit).

**Grievance:** A request from a member, or a provider with the member's written permission, for a reversal of the Behavioral Health Managed Care Provider's decision to deny authorization of an in-plan service prescribed for the member by an appropriately qualified practitioner.

**HealthChoices Program:** Pennsylvania's 1915(b) waiver program to provide mandatory managed care to Medical Assistance recipients who reside in Bucks, Chester, Delaware, Montgomery and Philadelphia counties. Medicaid recipients must now enroll in a Managed Care Organization which has entered into a contract with the Commonwealth of PA to provide comprehensive physical health services. In Philadelphia County, behavioral health services (mental health and substance abuse) are managed by Community Behavioral Health (CBH), a not-for-profit city-affiliated managed behavioral health care corporation established by the City of Philadelphia.

**Health Maintenance Organization (HMO):** An HMO is an organization that, for a prepaid fee, offers, provides or arranges comprehensive health care services to enrolled members. The HMO is licensed to provide its services to persons living within one or more counties in the state. HMOs typically offer a range of health care services at a fixed price (see Capitation).

**Individualized Education Program (IEP):** A federally-mandated written individual plan of services for all children with disabilities who qualify for special education. It is developed jointly by parents and school personnel.

**Inpatient treatment:** Services provided in an acute hospital or non-ambulatory setting under the care of a physician for no less than 24 hrs.

**Inquiry:** Any behavioral health member's request for administrative service or information, or to express an opinion. When specific corrective action is requested by the member, or determined to be necessary by the MCO, an inquiry is upgraded to a complaint.

**In-Plan Services:** Services which are the responsibility, under the HealthChoices program, of the behavioral health care Managed Care Organization.

**Intensive Case Management (ICM):** ICM is a service for persons with a major mental illness and/or a significant substance abuse problem who experience frequent hospitalizations or times of crisis and may be unable to get or keep a safe place to live, or identify, reach and maintain personal goals. Intensive case managers typically meet with clients once a week, but are also available on a 24-hour, 7-days a week basis. They generally assist clients to obtain and coordinate community resources such as income assistance, education, housing, medical care, treatment, vocational preparation and recreation.

**Intensive Outpatient Treatment (IOP):** Intensive Outpatient Treatment is appropriate for persons with alcohol or drug problems who need assistance in beginning or maintaining recovery, but who do not require detoxification or hospitalization. Outpatient Programs may be offered on various schedules, such as days, evenings, weekends and combinations of these. Programs are of varying durations, and may be used as a transitional step between an initial crisis and/or re-entry into daily living activities, depending on need.

**Interagency Team:** A multi-system team comprised of the child, where appropriate, the adolescent, a responsible family member, a representative of the mental health program, the case manager, and where applicable, the county children and youth, juvenile probation, mental retardation and drug and alcohol agencies, a representative of the responsible school district, MCO, PCP, and other agencies that are providing services to the child or adolescent.

**MA Provider Agreement:** Any provider wishing to provide services to eligible Medical Assistance or recipients must have a current agreement with the Pennsylvania Department of Public Welfare.

**Maintenance Psychiatric Partial:** Maintenance Psychiatric Partial Hospital is a non-hospital based program that provides less than 24 hour care for individuals who are stabilized post-crisis, but require ongoing, non-acute support than that available in traditional outpatient or aftercare programs. These programs provide an array of services which includes medical, psychological, social, cultural, behavioral, familial, educational, vocational and developmental services. Unlike the acute partial, the array of services are offered on a longer-term basis and are more related to psychosocial rehabilitation.

**Managed Care Organization (MCO):** An entity, operated by county government or a private vendor, organized to manage the financing and delivery of mental health and substance abuse treatment services to members under the HealthChoices program. CBH is the MCO to which this manual refers.

**Managed Care:** A broad term used to describe organizations that combine delivery and payment of health care services to control costs and utilization of services. Many states now use managed care as a way of ensuring quality in a cost-efficient manner within publicly funded programs. It may or may not include a capitation arrangement, by which the HMO is reimbursed with a set fee “per capita” or per person.

**Medicaid:** A medical benefits program for individuals who meet income criteria and are aged, blind, disabled, or members of families with dependent children. States have flexibility in setting their own eligibility criteria. The program is jointly paid for by the State and Federal governments, but administered by the State. Medicaid is the nation’s largest program providing medical and health-related services to more than 31 million of America’s poorest people. With about 1.3 million adults and children on public assistance, Pennsylvania ranks fifth in the nation in the number of its Medicaid recipients.

**Medical Assistance (MA):** The Commonwealth of Pennsylvania’s term for Medicaid. (Includes some reimbursable services that are not federally required.)

**Medicare:** A nationwide, federally financed health insurance program for people age 65 and older. It also covers certain people under 65 who are disabled or have chronic kidney disease. Medicare Part A is the hospital insurance program; Part B covers physicians’ services. Created by the 1965 amendment to the Social Security Act. Medicare is run by the Centers for Medicare & Medicaid Services (CMS), an agency of the federal government.

**Member:** Any person who is eligible for behavioral health services under the Medical Assistance program who is covered by the HealthChoices program.

**Mental Health (MH) Professional:** A person trained in a recognized clinical discipline including, but not limited to psychiatry, social work, psychology and nursing who has a graduate degree and mental health clinical experience.

**ODAP:** Formerly, the Commonwealth of Pennsylvania's Office of Drug and Alcohol Programs (now known as Bureau of Drug and Alcohol Programs —BDAP).

**OMH/MR:** Philadelphia's County Office of Mental Health and Mental Retardation.

**OMHSAS:** Pennsylvania Department of Public Welfare Office of Mental Health and Substance Abuse Services.

**Out-of-Plan Services:** Services which are non-plan and are not the responsibility of the MCO under the HealthChoices program but must be coordinated with in-plan service delivery.

**Pended Claim:** A claim that is put on temporary hold in order to determine what portion of the charges, if any, may be covered by a Third-Party Payor.

**Psychological Testing:** The employment of professionally recognized, standardized instruments that have been determined to be useful for a variety of diagnostic and treatment planning purposes.

**Primary Care Physician (PCP):** A primary care provider such as a family practitioner, general internist, pediatrician and sometimes an OB/GYN who serves as the initial interface between the member and the medical care system. Generally, a PCP supervises, coordinates and provides medical care to members of a plan. The PCP is the designated health care case manager contracted by the HMO. All general medical care is provided by the PCP and all specialty referrals must go through the PCP.

**Prior Authorization:** An authorization from Medicaid or other insurance carriers for the delivery of services. It must be obtained before the service is provided in order for the benefits to be paid. Emergency services do not require prior authorization.

**PROMISE Number:** Each provider has a PROMISE number assigned by the Pennsylvania Department of Public Welfare signifying participation in the Pennsylvania Medical Assistance Program.

**Provider Agreement:** The written agreement between the provider and the Managed Care Organization to render clinical or professional services to members to fulfill the requirements of the HealthChoices program.

**Provider Networks:** Organizations of health care providers that service managed care plans. Network providers are selected with the expectation that they will deliver quality care in a cost effective manner.

**Quality Improvement (QI):** Process by which the Managed Care Organization continuously measures, assesses and improves the performance of clinical processes and other processes involved in providing care and services in the provider network and internally.

**Quality Management:** A formal set of activities to assure the quality of services provided. Quality management includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

**Residential Continuum Treatment Facility (RCTF):** A part of a comprehensive treatment program for children and adolescents with severe to moderate behavioral health care needs in a community-based residential setting.

**Residential Treatment Facility (RTF):** A part of a comprehensive treatment program for children and adolescents with severe to moderate behavioral health care needs in a community-based residential setting.

**Resource Coordination (RC):** RC is a service for persons with serious mental illness and/or substance abuse problems who may have mild to moderate difficulty in social, job-related or daily living skills. Resource coordinators typically meet with clients anywhere from 2-3 times a month to every other month, depending upon need, but are also available during weekday business hours in the event of difficulty. They generally assist clients to obtain and coordinate community resources, and to provide training, support and assistance in living safely in the community and maintaining stable relationships, housing and employment.

**Risk Management:** A process intended to identify and minimize potential injury to persons and/or financial loss.

**Significant Incident:** Care or treatment that is not routine, and or is inconsistent with standards of practice, and/or has resulted in injury or potential harm to a BHS client.

**Supplemental Security Income (SSI):** A federal cash-assistance program which is based on certain eligibility criteria relating to disability or age and income. Disability under SSI means having a physical or mental impairment that prevents the individual from being gainfully employed and is expected to last for at least a year or result in death.

**Third Party Liability (TPL):** Refers to the existence of other insurance carriers that have primary responsibility for coverage.

**Unclean Rejected Claim:** A claim that must be returned to the provider or Third-Party Payor for additional information.

**Urgent care:** Any illness or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) period and, if left untreated, could rapidly become an emergent situation.

**UB-92 Claim Form:** Bill form used to submit hospital insurance claims for payment by insurance carriers. Similar to CMS 1500 but reserved for the inpatient component of health services.

**Utilization:** The extent to which members of a covered group use a program or obtain a particular service or category of procedures over a set period of time. This is usually expressed as the number of services used per year per numbers of persons eligible for the services.

**Utilization Management (UM):** The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria. UM integrates review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.

**Utilization Review (UR):** A formal review of utilization for appropriateness of health care services delivered to a member on a prospective, concurrent or retrospective basis. Utilization Review is a mechanism used to ensure that a member receives the appropriate level of care, that medical necessity is demonstrated, and that the level of care is the least restrictive and least expensive level necessary using established accepted guidelines.