Glossary of Terms

These definitions are general definitions applied for purposes of this manual. State law, certain practitioner Agreements and individual benefit contracts define some of these terms differently. In such cases, the definitions contained in the applicable law or contract will supersede these definitions. In the definitions below, and throughout this manual, “we,” “us” and “our” refer to Optum.

Adverse Determination

See definition for “Non-Coverage Determination”

Affiliate

Each and every entity or business concern with which we, directly or indirectly, in whole or in part, either: owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Agency

A non-Facility based outpatient Provider meeting specific criteria. Examples include, but are not limited to, Federally Qualified Health Centers (FQHC), Community Mental Health Centers (CMHC), State Licensed Outpatient Clinics, Community-based Service Agencies, and School Based Health Centers (SBHC).

Agreement (may be referred to as Provider Agreement or Provider Participation Agreement)

A contract describing the terms and conditions of the contractual relationship between us and a Provider under which mental health and/or substance abuse disorder services are provided to Members.

ALERT®

ALgorithms for Effective Reporting and Treatment (ALERT) is an outcomes-based system using Member responses to a validated survey, in conjunction with claims data, for the identification of Members who are at moderate to high risk for poor clinical outcomes.
Algorithm

A set of decision rules we apply to Member-specific data to determine whether there are any targeted clinical issues or risks.

Appeal

A specific request to reverse a non-coverage (adverse) determination or potential restriction of benefit reimbursement.

Authorization

The number of days or non-routine outpatient visits/units for which benefits have been applied as part of the Member Benefit Plan for payment (formerly known as Certification). Authorizations are not a guarantee of payment. Final determinations will be made based on Member eligibility and the terms and conditions of the Member’s Benefit Plan at the time the service is delivered.

Balance Billing

The practice of a Provider requesting payment from a Member for the difference between the UBH contracted rate and the Clinician or Facility’s usual charge for that service.

Behavioral Clinical Policies

The Behavioral Clinical Policies are used to determine whether a treatment or service is proven or unproven based on the published scientific evidence.

Behavioral Health Care

Assessment and treatment of mental health and/or substance use disorders (MH/SUD).

Care Advocate

An Optum employee who is a licensed clinical professional (e.g., nurse, doctor, psychologist, social worker, or professional counselor) who works with Members, health care professionals, physicians, and insurers to maximize benefits available under a Member’s Benefit Plan. EAP Care Advocates are referred to as EAP Specialists.
## Clean Claim

A UB-04 or a 1500 claim form, or its successor, submitted by a Facility or Clinician for MH/SUD health services rendered to a Member which accurately contains all the following information: Member’s identifying information (name, date of birth, subscriber ID); Facility or Clinician information (name, address, tax ID); date(s) and place of service; valid ICD-9 code or its successor code; procedure narrative; valid CPT-4 or revenue code; services and supplies provided; Facility charges; and such other information or attachments that may be mutually agreed upon by the parties in writing.

The primary avenue for Clinician claims submissions is electronically on *Provider Express*.

## Clinician

A licensed professional contracted to deliver behavioral health care services to Members (also known as a network Clinician or network Provider).

## Coinsurance

The portion of covered health care costs the Member is financially responsible for, usually according to a fixed percentage. Coinsurance often is applied after a deductible requirement is met.

## Community-based Service Agency

Includes peer support group services and drop in centers (clubhouse model), and have a business license, and/or state license as applicable.

## Community Mental Health Center (CMHC)

An entity that meets all applicable licensing or certification requirements for CMHCs in the State in which it is located.

## Co-payment

A cost sharing arrangement in which a Member pays a specified charge for a specified service (e.g., $20 for an office visit). The Member usually is responsible for payment at the time the health care is rendered. Typical co-payments are fixed or variable flat amounts for Clinician office visits, prescriptions or hospital services. Sometimes the term "co-payment" generically refers to both a flat dollar co-payment and coinsurance.
Coverage Determination Guidelines (CDG)

These guidelines are intended to standardize the interpretation and application of terms of the Member’s Benefit Plan including terms of coverage, Benefit Plan exclusions and limitations.

Credentialing

This refers to the process by which a Provider is accepted into our network and by which that association is maintained on a regular basis.

Deductible

The annual amount of charges for behavioral health care services, as provided in the Member’s Benefit Plan, which the Member is required to pay prior to receiving any benefit payment under the Member’s plan.

EAP (Employee Assistance Program)

Services that are designed for brief intervention, assessment and referral. These services are short-term in nature.

EPS/EFT (Electronic Payments and Statements/Electronic Fund Transfer)

A service which supports electronic claim payments and remittance advices. Claim payments are deposited directly into the designated bank account with access to all payment and remittance advice information via Provider Express.

Emergency

A serious situation that arises suddenly and requires immediate care and treatment to avoid jeopardy to life or health. For appointment access standards, see “Emergency — Life threatening,” “Emergency — Non-life threatening” and “Urgent.”

Emergency — Life Threatening

A situation requiring immediate appointment availability in which there is imminent risk of harm or death to self or others due to a medical or psychiatric condition.
Emergency — Non-life threatening

A situation requiring appointment availability within six hours in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm or death to self or others.

Exclusions

Specific conditions or circumstances listed in the Member’s Benefit Plan for which the policy or plan will not provide coverage reimbursement under any circumstances.

Facility

An entity that provides inpatient, residential, or ambulatory services and has contracted to deliver behavioral health care services to Members (also known as a network Facility).

Facility Contract Manager

An Optum professional dedicated to managing contractual relationships with hospitals and freestanding behavioral health programs and services for our network.

Federally Qualified Health Centers (FQHC)

A federally qualified health center is a type of Provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS), certain tribal organizations, and FQHC Look-a-Likes. An FQHC Look-A-Like is an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.

Fee Maximum

The maximum amount a participating Provider may be paid for a specific health care service provided to a Member under a specific contract. Reimbursement to Clinicians is based upon licensure rather than degree.

FWAE (Fraud, Waste, Abuse and Error)

Fraud: Intentional misrepresentation or concealing facts to obtain something of value. The complete definition has three primary components:

- Intentional dishonest action or misrepresentation of fact
• Committed by a person or entity
• With knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit

**Waste:** Inaccurate payments for services, such as unintentional duplicate payments, and can include inappropriate utilization and/or inefficient use of resources.

**Abuse:** Practices that directly or indirectly result in unnecessary costs to health care benefit programs. This includes any Practice that results in the provision of services that:
• Are not medically necessary
• Do not meet professional recognized standards for health care
• Are not fairly priced

**Error:** Mistakes, inaccuracies or misunderstandings that can usually be identified and fixed quickly.

### Group Practice

A Group of individually credentialed Clinicians who participate in the network under a Group contract and share a single Tax Identification Number. The Group Practice site(s) is the location of Practice for at least the majority of each Clinician’s clinical time. In addition, medical records for all patients treated at the Practice site are available to and shared by all clinicians, as appropriate.

### Health Plan

A Health Maintenance Organization, Preferred Provider Organization, insured Plan, self-funded Plan, government Agency, or other entity that covers health care services. This term also is used to refer to a Plan of Benefits.

### HIPAA

The Health Insurance Portability and Accountability Act, by which a set of national standards are set for, among other topics, the protection of certain health care information. The standards address the use and disclosure of an individual’s “Protected Health Information” (PHI) by organizations subject to the Privacy Rule (“covered entities”). These standards also include privacy rights for individuals to understand and control how their health information is used. For more information, please visit the Department of Health and Human Services website.
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<tr>
<th><strong>Independent Review Organization</strong></th>
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<td>An independent entity/individual retained by a private health plan, government Agency to review non-coverage (adverse) determinations (based on medical necessity) that have been appealed by, or on behalf of, a Member (also sometimes known as External Review Organizations).</td>
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<tr>
<th><strong>Least Restrictive Level of Care</strong></th>
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<td>The Level of Care (LOC) at which the Member can be safely and effectively treated while maintaining maximum independence of living.</td>
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<tr>
<th><strong>Legal Entities</strong></th>
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<tbody>
<tr>
<td>• United Behavioral Health (UBH)</td>
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<td>• United Behavioral Health of New York, I.P.A., Inc. (UBHIPA)</td>
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<tr>
<th><strong>Level of Care (LOC) Guidelines</strong></th>
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<td>Objective, evidence-based admission and continuing stay criteria for MH/SUD services. These guidelines are intended to standardize care advocate decisions regarding the most appropriate and available level of care needed to support a Member’s path to recovery.</td>
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<tr>
<th><strong>liveandworkwell.com</strong></th>
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<tr>
<td>A Member website which provides resources for wellness information, MH/SUD intervention, network referrals, certifications and other secure transactions.</td>
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<tr>
<th><strong>Medical Necessity</strong></th>
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<td>Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage: are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or state laws (also referred to as Clinical Necessity).</td>
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Member

An individual who meets all eligibility requirements and for whom premium payments for specified benefits of the contractual Agreement are paid. May also be referred to as a plan participant, enrollee, or consumer.

Medicare Coverage Summaries

Our Medicare Coverage Summaries are intended to promote optimal clinical outcomes and consistency in the authorization of Medicare benefits by Care Advocacy staff and Peer Reviewers. Medicare Coverage Summaries offer the guidance found in CMS’ National Coverage Determinations and Local Coverage Determinations.

MH/SUD

Mental Health and/or Substance Use Disorder.

Network Management

Consists of Network Managers and Associates who provide services and information to Providers. In addition, they may act as liaisons with other departments such as Care Advocacy, Account Management and Sales to contract and retain experienced mental health and substance abuse treatment professionals.

Non-Coverage Determination (NCD)

A denial, reduction, or termination of coverage, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on the eligibility of a Member or beneficiary to participate in a plan; and a denial resulting from utilization review, the experimental or investigational nature of the service, or the lack of medical necessity or appropriateness of treatment. The term “Adverse Determination” is sometimes used to describe NCDs.

Notification

A Benefit Plan requirement that Providers contact us when a Member accesses services. Notification, when required, should occur prior to the delivery of certain non-routine outpatient services and scheduled inpatient admissions, and as soon as reasonably possible for an emergency admission. Notification requirements include clinical information to determine benefit coverage.
Optum ID

Optum ID delivers a secure, centralized identity management solution that enables a single sign-on to all integrated applications. You register for an Optum ID once and use that Optum ID to access all of the associated applications seamlessly. You can access self-service tools to reset your password, recover your Optum ID, and maintain your profile.

Payor

The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member who is authorized to access MH/SUD services in accordance with the Agreement.

Prospective Program

Claim review completed before payment is made that may be denied due to a conflict with a reimbursement policy and/or when more information is needed before a claim can be processed. When more information is needed, a request for medical records will be sent to the Provider and/or Member, as appropriate.

Provider Dispute

A contracted Provider's written notice to Optum disputing or requesting reconsideration of a claim (or group of claims) that has been denied, adjusted, or contested, and for which the Member has already received service, and for which the Member has no financial liability. Under your Agreement, one level of dispute is available (unless two levels of dispute are required by Payor or law). For more information, see the “Appeals and Provider Dispute Resolution” section of this manual.

Provider Express

Optum’s website providing resources for Clinicians and Facilities. General information, manuals, forms and newsletters are available to both Clinicians and Facilities. A variety of secure, self-service transactions, including certification inquiry and claim entry, are available to network Clinicians and Group Practices.

Quality Assurance

A formal set of activities to review and affect the quality of services provided. Quality Assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient services. Federal and state regulations typically require health plans to have quality assurance programs.
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<th>Quality Management</th>
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<td>A continuous process that identifies opportunities for improvement in health care delivery, tests solutions, and routinely monitors solutions for effectiveness.</td>
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<tr>
<th>Retrospective Program</th>
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<td>Review of claims after payment has been made and are subsequently identified as having potential for Fraud, Waste, Abuse and/or Error activity.</td>
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<th>Routine Access</th>
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<td>A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others.</td>
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<th>School Based Health Center (SBHC)</th>
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<td>Provides a comprehensive array of behavioral health services, including outpatient, case management and telehealth services.</td>
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<th>State Licensed Outpatient Clinic (Non-CMHC)</th>
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<td>An organization that is licensed and/or accredited by a state entity to provide mental health and/or substance abuse services.</td>
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<tr>
<th>Telemental Health</th>
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<td>The provision of behavioral health services by a behavioral health Provider via a secure two-way, real-time, interactive audio/video telecommunication system.</td>
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<th>Urgent Access</th>
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<td>A situation in which immediate care is not needed for stabilization, but if not addressed in a timely manner could escalate to an emergency situation. Availability should be within 48 hours or less or as mandated by state law.</td>
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<th>Wellness Assessment (WA)</th>
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<td>A reliable, confidential, Member-driven instrument used to help identify targeted risk factors in addition to establishing a baseline for tracking clinical change and outcomes.</td>
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