

Partners in Recovery

Policies and Procedures Glossary

A

Abuse (Security type)

See Fraud and Abuse

Access

See Direct Care Access and Indirect Service Access

Accounting of Disclosures

A listing or compilation of information which accounts for certain disclosures of a member's PHI made by Partners in Recovery in the six years prior to the date on which the accounting is requested.

Accreditation

A voluntary survey process conducted to assess the extent of an organization's compliance with applicable standards set by an external accrediting agency.

Active Course of Treatment (Clinical)

Indicates treatment of an acute episode for a primary BH disorder and the condition under treatment could worsen or abrupt discontinuation could interfere with anticipated treatment outcomes. Generally evidenced with diagnoses, frequency, and type of treatment services rendered through claims, case management and/or provider's treatment records.

Actively Practicing (Practitioner or Provider)

The term actively practicing is defined according to state statute.

Ad Hoc

A situation whereby a member/client is referred to a provider who is not participating in the member's network, but has agreed to accept the member as a client at an agreed upon rate of reimbursement. The member/client's claims will then be reimbursed at their preferred or in network benefit level.

Ad Hoc Referral

An ad hoc referral is the process of identifying a qualified provider when the network assigned to a customer/product does not have an available provider who meets the geographic, clinical and/or specialty needs of the member. Ad hoc referrals require the approval of Care Management Center (CMC) leadership, confirmation of credentials and the negotiation of a single case agreement. In a life-threatening situation, the member is immediately referred to the closest emergency service. Provider reimbursement arrangements are secondary to obtaining emergency service.

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Administrative Determination

Determination following the request for use of available benefits based on non-clinical medical necessity decisions. (e.g.: – non-compliance with the plan requirements such as failure to pre-certify as allowed by state law, insufficient information to render a medical necessity determination within required decision timeframes).

Administrative Record

See Case Management Record.

Adverse Incident/Event

An adverse incident is a suicide, homicide, or other serious incident resulting in serious harm to a Magellan member or others which is committed by an individual who is a Magellan member at the time of the incident and which becomes known to Magellan staff.

Aftercare

Aftercare is a continuing program of treatment in an ambulatory setting and self-help services provided to members who have been discharged from care in an inpatient (acute or non-acute) setting.

Americans with Disabilities Act

A federal statute established in 1992 prohibits discrimination against persons with disabilities in all aspects of employment and commerce.

American Psychiatric Association

A medical specialty society of physicians that specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

Ancillary Provider

An entity which provides supplementary services to a member during their course of treatment (e.g. ambulance services) which are subject to reimbursement by Magellan.

Ancillary Services

Adjunct services rendered to a member that are performed as a complement or supplemental to the actual treatment. Services ancillary to behavioral health care include, but are not limited to:

- transportation.
- laboratory, radiology, pharmacy, physical therapy and well care visits.

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- for inpatient settings, all services other than room and board including emergency room services.

AOD (Alcohol and Other Drug)

AOD is the acronym for **a**lcohol and **o**ther **d**rug. It is interchangeable with chemical dependency (CD) or substance abuse (SA). AOD can be used to refer to a disorder type, service or provider type.

Appeal

A formal request by a practitioner or enrollee for reconsideration of a decision (such as a utilization review recommendation, a benefit payment, an administrative action or a

quality-of-care or service issue) with the goal of finding a mutually acceptable solution. See GRIEVANCE.

Appeal Mechanism

The formal process that a service provider or enrollee can use to request reconsideration of an organization decision.

Appeal (Medicare)

An appeal includes any of the procedures that deal with the review of an “adverse” organization determination of the health care services an enrollee believes he/she is entitled to, including delay in providing, arranging for or approving services, or an amount the enrollee must pay for services. These procedures may include reconsiderations by Magellan, independent review by the Center for Health Dispute Resolution (CHDR), hearing before Administrative Law Judges (ALJs), review by the Departmental Appeals Board (DAB), or judicial review.

Attestation

An attestation is a statement signed by an individual to certify that all information provided by that individual is true and accurate.

Authorization to Use and Disclose PHI Form (AUD) (formerly ROI)

An Authorization to Use and Disclose PHI Form (AUD) is a document that is signed and dated by the member giving permission to another party to use or disclose protected health information (PHI) for purposes other than treatment, payment, or health care operations.

Authorized Representative

An authorized representative is any individual designated by a member to represent his or her interest, act on his/her behalf, including but not limited to, a practitioner, spouse, parent, family member, or legal representative (such as a guardian, executor or attorney). This may be implied in situations deemed to be clinically emergent by Partners in Recovery or the provider acting on behalf of

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the member by requesting application of the member's benefits for payment of services.

B

Behavioral Health

1. A term similar to mental health; the field or industry that deals with psychiatric concerns and individual's well being.
2. The mental health state that exists in the absence of a psychiatric illness.

Clinical services delivered for treatment of psychiatric conditions, substance abuse conditions, and/or employee assistance services.

Behavioral Health Consultation

A behavioral health consultation is a psychiatric or substance abuse evaluation of a member that is performed by a qualified behavioral health practitioner who is someone other than the treating clinician.

Behavioral Health Services

Care and health related services for the evaluation and treatment of behavioral health disorders. Behavioral health disorders include mental health and AOD.

Business Associate

Business associate (BA) means, with respect to a covered entity, a person who:

1. On behalf of the covered entity performs, or assists in the performance of:
 - a) A function or activity involving the use or disclosure of PHI, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, and practice management; or
 - b) Any other function or activity regulated by the HIPAA Privacy Regulation; or
2. Provides, other than in the capacity of a member of the workforce of a covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of PHI from the covered entity or arrangement, or from another business associate of the covered entity or arrangement, to Partners in Recovery.

Some Partners in Recovery examples: claims payment companies; interpreter services, companies that perform satisfaction surveys, Physician Advisors.

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NOTE: Providers are not considered Business Associates of Magellan when serving in their usual role on the network (submitting patient information during the utilization management process).

C

Care Management Record

See Case Management Record

Care Manager (CM)

A Magellan Health Services employee who is a licensed behavioral healthcare practitioner (RN or master's-level or above) who collects the necessary clinical information required to make medical necessity determinations. A Care Manager may approve treatment services but can not render medical necessity adverse (organization) determinations.

Care Worker

Assists the care management team by locating services for patients with the goal of supporting continuity and coordination of care.

Case Management Record

A case management record (sometimes referred to as care management record) is a record of services performed by Partners in Recovery for an individual member. The services performed are dependent on the member's customer organization contract with Partners in Recovery. Most record documentation is maintained in Partners in Recovery computerized case management system and populated by one or more of the following; an automated file download from a customer organization (such as eligibility information), upload from a Partners in Recovery system/database (such as provider data) and inputted directly by Partners in Recovery staff.

A computerized record may be supplemented with external documents which are secured in a hard copy paper file. A record may include, but not limited to the following information and documentation: intake, clinical, unitization review/management services, EAP services, ICM services, CCM services, claims, portions of conversations with providers, various written confirmations/notices and forms (i.e. Statement of Understanding, release of information). Portions of the case management record such as member's treatment record, explanation of benefits, self critical records (such as case record audits and adverse incident audit materials), and provider incident reports are considered the "Administrative record.

Center for Medicare & Medicaid Services (CMS)

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The Center for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), is the division of the federal Department of Health and Human Services responsible for the administration and oversight of the Medicare and Medicaid programs.

Client Demographics

Refers to information that helps identify the person receiving services. Such information could include name, social security number or employee ID number, address, phone number, or other information.

Clinical Assessment

A clinical assessment is an evaluation of clinical information utilized to make provider referrals and/or medical necessity determinations.

Clinical Practice Guideline (CPG)

A Clinical Practice Guideline is a systematically developed descriptive tool or standardized specification for care that helps providers, members, care management staff and Physician Advisors determine appropriate services in specific clinical circumstances.

Clinical Urgency

The degree of the member's clinical situation. Magellan applies managed behavioral health industry levels: from least to highest - routine, urgent and emergent.

Clinician Advisor (CA)

A Clinician Advisor (CA) is a licensed, doctoral-level psychologist who renders medical necessity non-authorization decisions for cases in which the treating clinician is a registered nurse practitioner, social worker or other master's-level practitioner, or psychologist.

Closed Case

A closed case is one in which all client activity has been concluded and the client record has been closed within the appropriate clinical data system.

Community Resources

Community resources refers to programs and services which are typically not health care services delivered directly by a credentialed health care professional (e.g. supportive/supervised housing, job training and self-help groups) and which are helpful in supporting members to function independently in the community.

Complaint

A complaint is defined as any written expression of dissatisfaction. A verbal complaint is an expression of dissatisfaction where a Partners in Recovery

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employee is unable to resolve the customer's concerns to the customer's satisfaction during the initial call. In areas where call tracking technology to capture non-escalated concerns is not yet available, the definition of a complaint is as any written or verbal expression of dissatisfaction.

Complaint Resolution

A Complaint resolution is the process by which Partners in Recovery provides resolution for a member complaint that is made to the vendor, the customer or to Partners in Recovery directly.

Concurrent Review

The clinical review of care to determine medical necessity as the care is occurring. See Utilization Review/Management (UR or UM) process.

Confidential Information

Confidential information is any oral, written or electronic information about a member obtained by Partners in Recovery staff during the course of providing services to members for which Partners in Recovery is contracted.

Consumer

A consumer is a Magellan member who accesses Magellan services.

Contract

A contract is a written, legally binding agreement. Contract details include but are not limited to: the length of time the agreement will exist and what the rights, responsibilities, and expected outcomes are of all involved parties.

Contract Term

Contract Term refers to the period of time during which the written, legally binding agreement is in effect.

Co-payment or Co-pay

A co-payment is a fixed dollar amount to be paid out-of-pocket by the plan member each time he or she receives a specific service such as an office visit or prescription medication.

Covered Entity

1. A health plan, as defined in this glossary.
2. A health care clearinghouse, as defined in this glossary.
3. A health care provider who transmits any health information in electronic form in connection with a transaction covered by the HIPAA regulations, for example, claims or authorization forms.

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Credentialed

Provider has met all application, verification of credentials and review requirements for network participation.

Credentialing

The process of reviewing a practitioner's application for inclusion in the network. The review includes standards for education, licensure, certification, and experience.

Credentials Verification Organization (CVO)

Refers to credentials verification organization an industry term used for a department or organization that verifies the credentials of individual professional. NCQA offers CVO certification.

Critical Incident

A critical incident is a sudden traumatic event that produces intense emotional reactions and has the potential to interfere with individual and organizational functioning. These are events with circumstances so unusual and distressing that they typically produce emotional reactions that overwhelm normal coping mechanisms.

Custodial Care

Custodial Care is defined by Partners in Recovery to be "care that can be characterized by at least one of the following:

1. Care with the main purpose of assisting a member with the Activities of Daily Living (ADLs) and/or the more complex behaviors referred to as Instrumental Activities of Daily Living (IADLs). Examples of ADLs are bathing, grooming, dressing, feeding, and ambulating. Examples of IADLs are shopping, preparing food, taking medications properly, using a telephone and handling finances responsibly. (Comprehensive Textbook of Psychiatry, Seventh Edition, Sadock and Sadock, Lippincott Williams and Wilkins, 2000, p. 3155.)

or

2. Care for a member whose severity of illness requires a higher level of care than outpatient, but care which will not likely lead to a significant improvement in the member's condition. Despite the provision of treatment aimed at ameliorating symptoms of active disease, it is apparent that the member is not responding further to the active treatment elements, and is benefiting only from maintenance treatment and the non-specific aspects of the care being rendered. Such a determination is made after reviewing the degree of the member's response to date, as well as reviewing the member's prior treatment history, and considering the likelihood of response as derived from the published literature on the larger population of patients with similar

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disease and course.

Customer

A customer is the purchasing organization with which Partners in Recovery has a contract to provide managed care and/or Employee Assistance Program (EAP) products and services to members.

Customer Advisory Group (CAG)

The Customer Advisory Group is comprised of large Workplace Group employer accounts which meet annually to review Magellan Behavioral Health strategic plans, operational performance, quality improvements, and new product offerings in addition to offering networking and focus group activities.

D

De-identification

Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information. Information is de-identified only if:

1. The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:
 - a) Names;
 - b) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geo-codes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:
 - 1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
 - 2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
 - c) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
 - d) Telephone numbers;
 - e) Fax numbers;

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- f) Electronic mail addresses;
 - g) Social security numbers;
 - h) Medical record numbers;
 - i) Health plan beneficiary numbers;
 - j) Account numbers;
 - k) Certificate/license numbers;
 - l) Vehicle identifiers and serial numbers, including license plate numbers;
 - m) Device identifiers and serial numbers;
 - n) Web Universal Resource Locators (URLs);
 - o) Internet Protocol (IP) address numbers;
 - p) Biometric identifiers, including finger and voice prints;
 - q) Full face photographic images and any comparable images; and
 - r) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section; and
2. The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

Dependent Care

Refers to services provided to persons who are dependent on another for their care. Dependent care usually refers to childcare or elder care.

Desk-top Procedures

Detailed steps of an operation or activity in the order in which they should be performed.

Designated Record Set

A Designated Record Set is a group of records that is:

1. The medical and billing records about members maintained by or for a covered health care provider;

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2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
3. Used, in whole or in part, by or for the covered entity to make decisions about individuals.

For policy purposes, the term record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a covered entity.

Examples of items included in Partners in Recovery Designated Record Set are: eligibility and benefits info, authorization and non authorization correspondence, medical necessity determinations and all of the info utilized to make these determinations and rationale, EOBs, acknowledgement letters, appeals rights letters, clinical and administrative notes, and information used to make claims payment determinations.

QI information, including Treatment Record Reviews, QIAs, and information used for PPRCs are not a part of the designated record set.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

The official classification and grouping of mental disorders produced by the American Psychiatric Association. Commonly known as the DSM, each edition is numbered, such as IV (fourth edition) or V (fifth edition)

Direct Care Access

The timeliness in which a member can have services rendered by a practitioner or a provider of care given the nature of the member's clinical situation or clinical urgency.

Discharge Planning

The process by which Magellan staff assists the organization provider designated staff with obtaining a date and time with a participating provider and conducting the UR/UM process in a timely manner for the completion of applicable authorizations.

Disclosure (of PHI)

Disclosure means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Distant Site

The location where the provider is delivering the services via telehealth services.

Dual Diagnosis

Refers to a person who has both a substance abuse/dependence diagnosis as well as another mental health diagnosis.

Durable Power of Attorney

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Durable power of attorney is a legal document granting an agent the right to make some or all medical decisions on a enrollee's/member's behalf, should the enrollee/member become incompetent. In the case of a psychiatric advance directive, the durable power of attorney would be authorized to make decisions regarding mental health treatment.

Duty to Warn

Refers to a care provider's legal obligation to warn potential victims of violence as well as other appropriate authorities when a client makes a threat of violence.

E

Electronically Protected Health Information

Individually identifiable health information that is:

- Transmitted by electronic media
- Maintained in electronic media

Eligibility

An individual is eligible for services as defined by the contract. Eligible individuals may be active employees of an organization that has a contract with Magellan to provide services to individuals who live in the household of an active employee, or dependents living in the household of an active employee.

Eligible Practitioner/Provider

An eligible practitioner/provider is a practitioner/provider who is permitted to receive referrals to service Magellan members. Eligible practitioners/providers are usually PAR practitioners/providers, but a NON PAR practitioner/provider may be deemed eligible when a) the information on the Ad Hoc NON PAR Practitioner Pre-Screening form indicates that the practitioner/provider meets all Magellan credentialing eligibility criteria (see Network Practitioner Credentialing policy) and b) the practitioner/provider signs the attestation and returns it to Magellan staff.

Emergency Procedures

Emergency procedures are guidelines provided for foreseeable measures required to preserve life and safety of staff, prepare for, organize response too, and recover from an incident, natural hazard, disaster or possible terrorist action.

Emergency (Treatment) Services

Emergency services are network and non-network inpatient and outpatient services that are furnished by a provider qualified to provide emergency services when such services are needed to evaluate or stabilize an emergency medical

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condition. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

An emergency or crisis requires immediate intervention to prevent death or serious harm to the patient or others. It is characterized by sudden onset, rapid deterioration of cognition, judgment, or behavior, and is time limited in intensity and duration. It is considered to be a crisis situation requiring an immediate evaluation within a secure environment. The situation is so critical that the enrollee may not be able to access the needed intervention without assistance and transportation. Emergency Services include transportation to an emergency room. Situations requiring the initiation of involuntary commitment proceedings are considered emergencies. Care Managers must refer to local regulatory statutes to determine appropriate procedures. There does not need to be a threat to a patient's life to constitute an emergency. An emergency is determined at the time a service is delivered, and neither the member nor the facility is required to call Magellan for pre-certification of services.

Encryption

Encryption is the process by which a "key," known only by the user, is used to alter the contents of an electronic file and/or message so as to render it completely unreadable without the key.

F

Fee for Service

A fee arrangement under which a provider is paid a set fee for a provided service.

G

H

Health Care

Health Care means care, services, or supplies related to the health of a member, including:

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1. Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of a member or that affects the structure or function of the body; and
2. Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Health Care Operations

Health Care Operations include, but is not limited to, any of the following activities by Partners in Recovery:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical practice guidelines; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment. For Partners in Recovery these include: Quality Improvement Activities (QIAs), Prevention Programs, Intensive Case Management (ICM), and Ambulatory follow-up, among other activities related to health care management.
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities. For Magellan these include: treatment record reviews (TRR), provider profiling activities, HEDIS, and QI surveys, among other activities.
3. Business management and general administrative activities, including, but not limited to:
 - a) Management activities relating to implementation of and compliance with the requirements of the HIPAA Privacy Regulation;
 - b) Customer service, including the provision of data analyses for policy holders, plan
 - c) sponsors, or other customers, provided that PHI is not disclosed to such policy
 - d) holder, plan sponsor, or customer;
 - e) Resolution of internal complaints and grievances;
 - d) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered

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entity or, following completion of the sale or transfer, will become a covered entity;

- e) Creating de-identified health information; and marketing activities.
- 4. Conducting or arranging for medical review, legal services, and auditing functions, include fraud and abuse detection and compliance programs, including Magellan's Special Investigations Unit (SIU).
- 5. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or
- 6. Placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance); and
- 7. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating, including formulary development and administration, development or improvement of methods of payment or coverage policies.

Health Information

Health Information is any information, whether oral or recorded in any form or medium, that:

- 1. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
- 2. Relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member.

Health Maintenance Organization (HMO)

A form of managed care in which insurers and providers are coordinated to provide predetermined healthcare services for members of the organization for a specific all-inclusive fee

Health Plan

For most of Magellan's business, Magellan is a Business Associate to our various customer Health Plans, but for purposes of simplicity and uniformity we approach compliance with the HIPAA Privacy Regulation as though we are the Health Plan. In some cases, such as staff model offices and EAP services, Partners in Recovery meet the definition of Health Care Provider. Some other examples of Health Plans include: Medicare+Choice Organizations, TRICARE, Federal Employees Health Benefits Programs, and HMOs.

HIPAA

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Health Insurance Portability and Accountability Act - The Administrative Simplification provisions of HIPAA define standards for EDI, Coding, and the privacy and security of individually identifiable health information.

Homicidal Ideation

An implied or direct threat by one person to harm, seriously injure, or kill another person. In such instances a professional has a duty to warn the person on whom the threats are being made, as well as any necessary authorities.

Household Member

A household member is any individual who resides in the member's household.

I

Indirect Treatment Relationship

An Indirect Treatment Relationship is a relationship between a member and health care provider in which:

1. The health care provider delivers health care to the member based on the orders of another health care provider; and
2. The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the member.

Individual

An individual is a member, a provider, or a Magellan employee.

Individually Identifiable Health Information (IIHI)

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - a) That identifies the individual; or

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b) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Inpatient

A direct care setting in which a member is admitted to a controlled environment with healthcare personal on-site 24 hours a day. Care in an inpatient setting can be acute (acute hospitalization) or sub-acute, also referred to as non-acute, (residential, inpatient rehabilitation, skilled nursing).

Intensive Outpatient Programs (IOP)

Is a specific setting of care rendered in an intermediate ambulatory level of care. It is commonly provided by a licensed or certified organizational provider consisting of 2 to 4 hour sessions occurring 3 – 5 times a week.

Intermediate Ambulatory

Evaluation and treatment in a non-routine ambulatory setting such as a partial hospital program, intensive outpatient and day treatment.

J

K

L

Length of Stay

Number of consecutive inpatient hospital days (acute and sub acute).

Level of Care

An environment that provides behavioral treatment within a varying intensity of service options necessary to ameliorate the severity of the behavioral symptoms.

Level of Risk

Level of risk refers to the determination of a member's potential for violence, either to himself or herself, to others, or in the workplace.

Limited Data Sets (LDS)—

A limited data set is protected health information that **excludes** the following direct identifiers of the individual or of relatives, employers, or household members of the individual:

1. Names;
2. Postal address information, other than town or city, State, and zip code;
3. Telephone numbers;

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4. Fax numbers;
5. Electronic mail addresses;
6. Social security numbers;
7. Medical record numbers;
8. Health plan beneficiary numbers;
9. Account numbers;
10. Certificate/license numbers;
11. Vehicle identifiers and serial numbers, including license plate numbers;
12. Device identifiers and serial numbers;
13. Web Universal Resource Locators (URLs);
14. Internet Protocol (IP) address numbers;
15. Biometric identifiers, including finger and voice prints; and
16. Full face photographic images and any comparable images.

Live Call Transfer

Live call transfer is the process by which a Customer Service Associate(CSA) transfers a member to a Care Manager (CM) while maintaining the member live on the phone until the CM takes ownership of the call.

M

Magellan Network

All active providers listed in the Integrated Provider Database that are credentialed and contracted by Magellan.

Medicaid

An entitlement program administered by the states that provide health care services for low-income persons under the age of 65. The Medicaid program is

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funded through Federal and state funds. States have different Federal matching rates to fund the services provided under their Medicaid programs. The Medicaid Program provides medical benefits to groups of low-income people, some who may have no medical insurance or inadequate medical insurance. Although the Federal government establishes general guidelines for the program, the Medicaid program requirements are actually established by each State. Whether or not a person is eligible for Medicaid will depend on the State where he or she lives. States are required to include certain types of individuals or eligibility groups under their Medicaid plans and they may include others. States' eligibility groups will be considered one of the following: categorically needy, medically needy, or special groups.

Medical Necessity

See Utilization Review/Management (UR or UM) process.

Medical Necessity Criteria (MNC)

The Medical Necessity Criteria (MNC) are the specific set of guidelines developed by the Magellan Health Services medical leadership for the purpose of guiding medical necessity determinations.

Medical Necessity Determination

Medical necessity determinations are decisions regarding the medical and clinical appropriateness of requested services based upon information provided by the treating provider and/or the member.

Medicare

Medicare is the U.S. government's plan for paying certain hospital and medical expenses for those who qualify, primarily those over 65. Benefits are provided regardless of income level. The program is government subsidized and government operated.

Part A, Hospital (HI), provides for inpatient hospital services and post hospital care.

Part B, supplementary Medical Insurance (SMI), pays for medically necessary doctors' services, outpatient hospital services and a number of other medical services and supplies

not covered in Part A. Enrollment in Part B is voluntary and available for a small premium.

Individuals who qualify for Medicare may still be eligible for coverage under their employer's or organization's group health benefits plan. In these cases, it is important to know which payer is primary—whether the plan or Medicare pays first.

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Medicare Advantage Organization (MAO) (formerly called Medicare+Choice Organization (M+CO))

An entity organized and licensed by a State as a risk-bearing entity that is certified by CMS that is certified by CMS as meeting the MA contract requirements and is authorized to administer and provide Medicare services for Medicare enrollees who have enrolled with the MAO. The MAO contracts with Magellan to manage the mental health and substance abuse portion of the Medicare benefit.

Medicare Advantage Organization (MAO) Plan

Health benefits coverage offered under a policy or contract by an MA organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan (or in individual segments of a service area, under § 422.304(b)(2)).

Medicare Advantage Organization (MAO) Plan Enrollee

An MA eligible individual who has elected an MA plan offered by an MA organization.

Medicare Allowable Reimbursement

A reimbursement methodology established by the Center for Medicaid and Medicare Services (CMS) based upon the relative value (RBRVS) of professional services in various geographic service areas of the country. Medicare providers agree to be paid at or below Medicare Allowable Reimbursement for services to Medicare eligible members.

Medicare+Choice Organization (M+CO)

See Medicare Advantage Organization.

Medicare Grievance

Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which Magellan or a delegated entity provides health care services, regardless of whether any remedial action can be taken. A grievance may include a complaint about any of the following:

1. Access to care or service;
2. Quality, timeliness, and/or appropriateness of care or service;
3. Attitude and service orientation of practitioner/provider, practitioner/provider's staff, or Magellan staff;
4. Utilization management process;
5. Inaccurate or inadequate information;
6. Care or service rendered by practitioners/providers;

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7. General dissatisfaction with a co-payment amount; or
8. A decision not to expedite an organization determination or reconsideration.

Medicare Inpatient Facility Prospective Payment System (IPF PPS)

Hospital per diem payment formula for inpatient psychiatric services furnished to Medicare Advantage members in hospitals and exempt units required by the Medicare, Medicaid Balanced Budget Refinement Act of 1999. This payment formula assures a per diem payment amount that reflects the differences in patient resource use and costs among such hospitals.

Minor

A minor is an individual who has not attained the age of majority, as specified by applicable State law, or if no age of majority is specified by state law, the age of eighteen.

Monitor

A process for capture, analysis, and reporting of project progress to ensure established procedures are being followed (e.g. audit process flows, observation data log, test data log, issues/problem resolution log).

N

Network

Network refers to the group of providers, practitioners or affiliates who are typically credentialed and contracted to provide services to Magellan members. A network of providers may also be “owned” by a customer or “rented” to service customer’s health plan members. In this case Magellan may not hold the provider agreement or may not be responsible for credentialing the providers.

Network (Security)

Network refers to the internal infrastructure comprised of computers, servers, printers, routers and switches forming a logical, functional, cohesive proprietary unit.

Network Administration

Centralized provider network administrative services such as provider re/credentialing, contract execution, data maintenance, document management

Network Availability

A network’s ability measured by quantity (number of specific provider type), density (ratio of specified providers to members) and service area distribution

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(sometimes referred to as geo-access) to meet the potential care needs of the entire membership.

Network Status

Active-- a network status category indicating there are no restrictions on referrals to the provider.

Exclude-- a network status category indicating that the practitioner or provider's participation in the network is terminated.

Hold-- a network status category indicating that a concern has been identified and new referrals to the provider are suspended. Existing authorizations to a provider in "hold" status remain active and are eligible for claims payment.

Pend-- a network status indicating that, while a concern has been identified, the practitioner and/or provider can continue to receive new referrals.

Suspend--new referrals to the provider are suspended. Existing authorizations to a suspended provider remain active and are eligible for claims payment. Termination from the network is imminent.

Terminated-- a network status indicating that the provider's participation in the network is terminated.

New Technology

Any new pharmacological agent, medical device, assessment or therapeutic procedure.

No-hold Transfer

See Live Call Transfer

Non Life-Threatening Emergency

A non life-threatening emergency is a condition that requires rapid intervention to prevent acute deterioration of the member's clinical state, such that gross impairment of functioning exists and is likely to result in compromise of the member's safety. A non life-threatening emergency is characterized by sudden onset, rapid deterioration of cognition, judgment, or behavior, and is time limited in intensity and duration.

Unlike members who present with life-threatening emergencies, members presenting with non life-threatening emergencies can be triaged through a face-to-face evaluation within six (6) hours. The evaluation does not immediately require a secure environment.

Members may present with emergencies initially considered to be life threatening but because of the family or social resources that can be mobilized, the emergency can be contained such that the immediate safety of the member is achieved. If those resources cannot be sustained over a maximum of six (6) hours, however, the situation is defined as life threatening. Member referrals to providers for non-

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life-threatening emergencies must be completed within a time frame that allows the member to be seen by an approved provider within six (6) hours of the request for services. EAP Consultants are responsible for managing the ad hoc referral process for members in non-life-threatening emergency situations.

Notice of Certification

A letter generated that notifies the member and other parties of the decision to authorize medically necessary care.

Notice of Discharge and Medicare Appeal Rights (NODMAR)

Notice provided to Medicare enrollees prior to being discharged from inpatient care when the enrollee disagrees with the discharge or Magellan will no longer recommend payment for continued inpatient stay and the attending physician concurs with Magellan's determination.

O

Organizational Providers

Organizational providers include ambulatory, residential, freestanding or general hospital, psychiatric and addiction disorder behavioral healthcare treatment facilities, agencies, community mental health centers (CMHCs) and clinics.

Originating Site

The location where the member may receive health care via telehealth services.

Outpatient

Care services rendered in an ambulatory setting also referred to as routine ambulatory generally delivered by individual practitioners or by an organizational provider such as a hospital outpatient clinic, mental health clinic, or other qualified facility. Magellan defines behavioral health outpatient care as two or less hours a week.

Oversight

Oversight is the process by which Magellan monitors the service delivery, staffing, credentialing, customer needs, customer satisfaction, and the complaint resolution process that are implemented by a vendor.

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P

Partial Hospitalization Program

A setting which provides a specified number of hours of structured treatment programs per week during daytime or nighttime hours. Also known as day treatment programs or evening programs.

Participating (PAR) Provider

A participating (PAR) provider has one or more agreements with Magellan and/or its affiliated companies to provide mental health, substance abuse and or employee assistance program (EAP) services to Magellan members and has completed verification of credentials within the past three years.

Patient

A patient is an individual who is in treatment with a practitioner or provider.

Personal Representative

A Personal Representative is an adult or an emancipated minor. If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, Partners in Recovery treat such person as a personal representative, with respect to protected health information and the individual's health care. If under applicable law an executor, administrator, or other person has authority to act on behalf of a deceased individual or of the individual's estate, Partners in Recovery treats such person as a personal representative, with respect to protected health information relevant to such personal representation.

If under applicable law a parent, guardian, or other person acting in loco parentis has authority to act on behalf of an individual who is an unemancipated minor in making decisions related to health care, <Insert PNO Name> treats such person as a personal representative, with respect to protected health information. There are exceptions in cases where such person may not be a personal representative of an unemancipated minor, and the minor has the authority to act as an individual, with respect to protected health information:

1. The minor consents to such health care service; no other consent to such health care service is required by law, regardless of whether the consent of another person has also been obtained; and the minor has not requested that such person be treated as the personal representative;
2. The minor may lawfully obtain such health care service without the consent of a parent, guardian, or other person acting in loco parentis, and the minor, a court, or another person authorized by law consents to such health care service; or

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3. A parent, guardian, or other person acting in loco parentis assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.

Physician Advisor (PA)

A Physician Advisor (PA) is either board-certified in psychiatry or board-certified in a specialty other than psychiatry with additional background and training in substance abuse treatment. The PA has appropriate training and professional experience relative to the case under review and renders medical necessity determinations for cases in which the treating clinician is a registered nurse practitioner, social worker or other master's level practitioner, psychologist, or physician.

Practitioner

A practitioner is an individual professional (such as a psychiatrist, psychologist, social worker, psychiatric nurse, counselor or other mental health and/or substance abuse professionals or group of such professionals licensed to provide employee assistance program (EAP), mental health and/or substance abuse services in accordance with applicable laws.

Note: Medicare practitioners have a Medicare Unique Physician Identification Number (UPIN) and have signed a Medicare contract addendum.

Pre-authorization

A request for application of the member's benefits toward a specific service by a review

process that is defined by the customer organization's contractual requirements (i.e. utilization review) before (prospective) to services being rendered. This is typically required for managed care products. Can also be referred to as "pre-certification".

Pre-certification

See [Pre-authorization](#).

Pre-contract

Pre-contract refers to the period of time prior to the execution of the written, legally binding agreement between Partners in Recovery and a vendor.

Presenting Problem

The problem a client presents as being the reason for seeking professional services.

Primary Care Physician (PCP)

A primary care physician is a physician who is responsible for primary care needs of a member (and coordination of special care needs) for a member in a managed

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care plan. In HMOs a member chooses a PCP at the time the member joins the HMO.

Professional Provider Review Committee (PPRC)

The Professional Provider Review Committee (PPRC) is a committee composed of licensed clinicians who are responsible for Magellan credentialing and re-credentialing decisions and processes, site evaluations for participating (PAR) providers, treatment record guidelines, and provider profiling.

Protected Health Information (PHI)

Protected Health Information is health information that is:

1. Created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Related to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and
 - a) That identifies the member; or
 - b) With respect to which there is a reasonable basis to believe the information can be used to identify the member; and
3. Is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

Provider

A provider is an institution, such as a facility or an organization, licensed to provide mental health and/or substance abuse services in accordance with applicable laws. Generally, unless otherwise specified, the term provider refers not only to institutions, but also to individual

professionals, (such as psychiatrists, psychologists, social workers, psychiatric nurses, counselors and other mental health and/or substance abuse professionals or groups) who are licensed to provide mental health and/or substance abuse services in accordance with applicable laws.

Provider (Medicare)

Medicare providers are institutions, such as facilities and organizations, licensed to provide mental health or substance abuse services in accordance with applicable laws. They have a Medicare Unique Physician Identification Number (UPIN) and have signed a Medicare contract addendum. Unless otherwise specified, the term provider refers not only to institutions, but also to individual professionals.

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Provider Networks

A specific set of providers designated to serve the covered membership of a customer as defined by member location, product and service requirements, the type and credentialing status of eligible providers, executed provider contract documents, and rate of reimbursement.

Proximal Event

A proximal event is the last event that directly results in the member seeking treatment.

Proximal Factors

Proximal factors are the elements that surround, or are related to, the member's presenting problem.

Prudent Layperson (Emergency)

Is a standard based on federal, and most states, regulation to be applied by health care insurers, chiefly managed care plans, in cases where a claim for payment for emergency room/department services against a member's benefits did not meet explicit benefit.

criteria. In essence, the "prudent layperson" standard means evaluating the emergent nature of a member's condition and symptoms that led him/her to seek emergency medical care as reasonable compared to a person without any medical training in the same situation.

Psychiatric Advanced Directives

A psychiatric advance directive is a legal document providing specific instructions to mental health providers about an individual's wishes regarding mental health care in the event the person becomes too ill to articulate such preferences, and appointing a durable power of attorney to make medical decisions on the member's/enrollee's behalf. An advance directive may contain information about the member's/enrollee's consent or refusal with regard to identified courses of mental health treatment.

Psychiatric Illness

Any mental disorder that is formally defined by a set of signs and symptoms. Signs and symptoms are any physical or mental indication that stands for something else.

Psychotherapy Notes

Notes recorded by a health care provider who is a behavioral health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the member's medical record.

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Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. This information is expected to be documented in the patient's medical record.

Q

Qualified

Qualified refers to a provider who, according to preliminary screening, meets credentialing eligibility requirements and who agrees to attestation.

Quality of Care

The term quality of care refers to aspects of the delivery of treatment and service including appropriateness of care, continuity of care, accessibility to care and care delivery.

Quality Improvement Committee (QIC)

A Quality Improvement Committee (QIC) within a CMC is responsible for monitoring the

quality program, establishing and maintaining mechanisms for the identification and review of quality of care and service issues and providing a method for providers, members, and other relevant stake holders to have input into the QI program.

Quality Improvement Organization (QIO)

A Quality Improvement Organization is a group of physicians or providers who have a contract with the Center for Medicare & Medicaid Services (CMS) to conduct reviews of inpatient adverse organization determinations, and conduct quality reviews. Each state has their own QIO. These were formerly known as Peer Review Organizations (PROs).

Quality Improvement Program (QI)

The scope of the Magellan quality improvement (QI) program includes the objective and systematic monitoring of the quality of behavioral health care, prevention and support services provided to the members of <Insert PNO Name>.

Quality Improvement Review Committee (QIRC)

The QIRC is a national committee reporting to the NQC. It is responsible for monitoring the MHS Quality Program, patient safety enhancement and establishing and maintaining mechanisms for identification and review of quality care and service issues.

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R

Reconsideration (Medicare)

This is an appeal and consists of the review of an “adverse” organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit or that is obtained by Magellan or CMS. The Magellan reconsideration is one of the levels of the appeals process.

Record

A record consists of all documents, papers, magnetic or other tapes, databases, microfilm, documentation of conversations, computer generated printouts, audio or video discs or other discs used to store and retrieve information, and any other documentary evidence, regardless of physical form or characteristics, and including all duplicates thereof, made or received pursuant to a law, contractual obligation, or any activity performed in connection with the official business of any office of Magellan Health Services and its subsidiaries.

Re-credentialing Anniversary Date

The re-credentialing anniversary date is the date in time up to 36 months from the date of a provider’s initial credentialing and/or prior re-credentialing.

Release of Information

See Authorization to Use and Disclose PHI Form (AUD).

Relevant information

Any documents, records or other information that were submitted, considered or generated in the course of making the benefit determination regardless of whether the information was relied upon in making the benefit determination; and (ii) any policy or guidance with respect to the plan relating to the non- authorized treatment option or benefit for the member’s diagnosis and/or the determination regardless of whether the policy or guidance was relied upon in making the benefit determination.

Routine Services

Routine refers to a referral for services that is made when the member’s clinical urgency is considered to be sufficiently stable to allow for a first face-to-face assessment by a direct care provider to take place within the industry standard of ten (10) business days of the member requesting the services from the provider of care,

Risk Management

The identification and reduction of risks in order to reduce liability exposure.

Routine Business Information

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Routine business information includes essential and basic member information required to conduct normal business operations related to eligibility and benefits information, claims processing, complaints and appeals.

S

Secondary Treatment

Secondary treatment services are those which are provided by professionals other than the treating clinician, for instance, a psychiatrist who performs a consultation or a social worker who conducts a daily living skills group at a partial hospitalization program, and individuals from relevant medical delivery systems, including Primary Care Physicians.

Sensitive

Sensitive is the level used to identify information that contains Protected Health Information or financial information that meets the control requirements of the Sarbanes-Oxley Act.

Significant Others

Significant others are individuals who are in a relationship with a member, including but not limited to, partners who do not reside in the household, non school-age adult children living outside the household, extended family or friends who do not live in the member's household.

Standard Operating Procedures (SOP)

Detailed steps of an operation or activity in the order in which they should be performed.

Substance Use

Substance use refers to the use of mood altering substances, including alcohol and other drugs.

Substance Use Disorders Suicidal Ideation

The intentional use of drugs or alcohol to alter mood or behavior and in a manner that is detrimental to the individual or society. Implied or direct threats by one person to harm, seriously injure, or kill him/herself. In such instances, a professional has a duty to take the necessary precautions to ensure the safety of the suicidal person.

Support Group

Community resources which may/may not be facilitated by a trained professional and focus on the group rather than the individual. Support groups often focus on a specific problem or issue, such as alcoholism.

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T

Telehealth

The use of two-way¹, real-time, telecommunication to provide and support health care delivery, diagnosis, consultation, and treatment when distance separates the member and provider. It is not telephonic counseling or one-way² communication such as email.

Threat of Violence (TOV)

Threat of Violence (TOV) refers to any clinical presentation in which a clinician determines the member/client is risk for inflicting harm to self or others, including but not limited to, child abuse, spouse abuse, elder abuse, and workplace violence and/or presenting a life threatening, high-risk, or critically emergent situation. This includes the threat of workplace violence, as well as suicidal and homicidal ideation.

Transaction

A Transaction is the transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

1. Health care claims or equivalent encounter information;
2. Health care payment and remittance advice;
3. Coordination of benefits;
4. Health care claim status;
5. Enrollment and disenrollment in a health plan;
6. Eligibility for a health plan;
7. Health plan premium payments;
8. Referral certification and authorization;

¹ *Interactive telecommunications system*

Multimedia communications equipment that permits two-way, real-time interactive communication between the member (originating site) and provider (distant site).

² *Asynchronous store and forward technologies*

The transmission of a member's medical information from an originating site to the provider at the distance site using one way communication, such as emailing documents.

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9. First report of injury;
10. Health claims attachments; and
11. Other transactions that the Secretary, department of Health and Human Services may prescribe by regulation.

Treatment

Treatment is the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Treatment Provider

Treatment providers are institutions, such as facilities and organizations, licensed to provide mental health and/or substance abuse services in accordance with applicable laws. Unless otherwise specified, in this policy the term provider refers not only to institutions, but also to individual professionals who provide services to client organization employees.

Treatment Record

The member's treatment record sometimes referred to as the medical record or the case record is generated and maintained by the member's treating provider.

Treatment Request Form (TRF)

The Treatment Request Form (TRF) is a form developed by Magellan to be submitted by providers to request prior authorization of additional outpatient sessions.

Triage

Triage is the process by which a Care Manager evaluates a member's presenting problem to determine the clinical priority for referral to direct care treatment.

U

Unauthorized Use and Disclosure (of PHI)

Unauthorized Use or Disclosure, with respect to PHI, is any application, divulging, examination, release, sharing transfer, or utilization that is not permitted or does not comply with the rules specified by 45 CFR 160 and 164.

Urgently Needed Services

Covered services, other than emergency services provided when a member is temporarily absent from the plan's service area when the services are medically

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necessary and immediately required as a result of an unforeseen illness, injury or condition, and it was not reasonable to obtain the services through the plan. An ad hoc referral to an OON provider is typically required in this situation.

Use (of PHI)

Use, with respect to PHI, is the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

Utilization

The frequency of how much a benefit is used. Can refer to how often a particular member uses the benefit, or the percentage of employees within an organization who utilize the benefit plan within a specific time frame, such as one year.

Utilization Review/Management (UR or UM) process

Utilization review or management is a process by which trained and licensed clinicians optimize behavioral health care resources through evaluating a request for application of benefits toward specific care services via explicit (compare specified care services to

benefits using medical necessity or clinical criteria) and implicit (peer review by a physician or other type of clinician equivalent to requestor or requested service) review. Medical necessity or clinical criteria is a clinically sound, research-based decision making tool. If the process includes an implicit review, the results of this review are considered the medical necessity determination which is used to base the determination. The process can occur before services are rendered (pre-service), while services are being rendered (concurrent) or after services have been rendered (post-service or retrospective).

Utilization Review

A review in which the insurance/managed care program determines the level of use of a service and thereby makes determinations regarding the appropriateness and quality of care. Such review often guides modifications to programs to better serve members. Utilization review can occur before (prospective), during (current) or after (retroactive) services are provided.

V

W

Warm Transfer

Warm transfer refers to when the Employee Assistance Program (EAP) Consultant remains on the line with a caller while the EAP Consultant connects the caller with the service provider.

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Wellness

Refers to making members aware of the effects of various behaviors and lifestyles and of the potential health complications as a result of such behaviors. The goal of wellness is to improve member's behavioral health through education and early identification of potential behavioral and/or health problems.

X/Y/Z