
GLOSSARY OF TERMS

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

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

Abuse or Inappropriate Billing

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

Access Standards

ValueOptions® of California has adopted the following standards of access for appointments:

Emergencies

In an emergency situation, the member must be offered the opportunity to be seen in person immediately.

Contracted providers who do not maintain coverage 24 hours per day, seven days per week are required to maintain a system for referring members to a source of emergency assistance during non-business hours. The preferred methods are through a live answering service or an on-call pager system. However, providers may maintain a reliable recorded answering machine system; members experiencing an emergency must be given clear instructions about accessing immediate assistance after hours.

Non-Life Threatening Emergent

When there is significant risk of serious life deterioration such as impending inpatient hospitalization, the member must be seen within six (6) hours of the request.

Urgent

In an urgent situation, a member must be offered the opportunity to be seen within 48 hours of the request.

Routine

In a routine situation, a member must be offered the opportunity to be seen within ten (10) business days of the request for an appointment for Mental Health and Substance Abuse services and within seven (7) calendar days of the request for an appointment for Employee Assistance Program services.

Accessibility

The extent to which members have access to medically necessary services. This may include the number and geographic distribution of providers, number and types of specialists, number and geographic distribution of hospitals, emergency services, and ancillary facilities.

Acute Condition

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

Administrative Services Only (ASO)

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

Adverse Incidents

Occurrences that represent actual or potential serious harm to the well being of a ValueOptions® of California member, or to others by a ValueOptions® of California member who is in active behavioral health treatment/EAP services, or has been recently discharged (i.e. within the past 6 months) from behavioral health treatment/EAP services. Adverse Incidents must be reported to ValueOptions® of California within 24 hours of learning of such incident.

Americans With Disabilities Act (ADA)

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

ValueOptions® of California expects participating providers and EAP Affiliates to comply with all provisions of The Americans with Disabilities Act (ADA) and other federal, state or local laws or municipal codes applicable to all services. Services should be handicap-accessible for physically, visually, and hearing impaired participants. The provider or EAP Affiliate adapts his/her environment to the special needs of participants. Accessibility of services is an integral component to meeting need equitably.

American National Standards Institute (ANSI)

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

American Society of Addiction Medicine (ASAM)

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

Appeal

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

Assignment of Benefits

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

Authorization

Approval for a specific covered service to be delivered to a covered member. An authorization represents agreement that the service is clinically necessary under ValueOptions® of California clinical care criteria. Authorization is not a guarantee of payment. Payment is subject to member eligibility, provider licensure/certification and benefit limits at the time services are provided.

Availability

The extent to which members can obtain medically necessary services at the time they are needed. This may include telephone availability or appointment availability.

Balance Billing

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

Back to Work Conference*

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

Beneficiary

Any individual that is covered by an employer's benefit plan. May also be referred to as a member.

BenefitConnect

An information technology application that serves as a comprehensive warehouse for all general client account information, benefits and eligibility requirements and appeals information, as well as claims and referral guidelines. This application reduces customer service call processing times, allowing more efficient service to our callers. This application is for ValueOptions® of California internal use only.

Bulletin Board System (BBS)

Isolated dial-in sites that users can post messages and exchange files using modems to access the system hub.

Case Activity Form (CAF)

Case Activity Form serves as the participant case record for EAP services. This form must be completed and returned to ValueOptions® of California minimally at case opening and case closing. The Case Activity Form may be submitted during the intervention phase of EAP services. The form can be located at www.valueoptions.com.

CareConnect

An information technology system that answers the specific needs of clinical care staff, who employ the system to quickly focus on the most pertinent clinical data for each member, easily locate and view historical data summaries to efficiently formulate cases, as well as access advanced tools that allow care managers to devise, monitor, follow-up, and report on individualized treatment plans. For ValueOptions® of California internal use only.

Center for Medicare and Medicaid Services Form (CMS 1500)

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

Certification

The number of days, sessions or visits ValueOptions® of California approves as medically necessary.

Certified Employee Assistance Professional (CEAP)

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

Chain of Custody*

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

Claim

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

Clean Claim

Providers are to file claims for covered services in the form and manner required by ValueOptions® of California as specified below (herein referred to as a “clean claim”). Clean claims are to be *received* by ValueOptions® of California within 90 days from the date of service. A clean claim is a UB-92 or CMS-1500 (formally known as the HCFA-1500 claim form), or its successor, submitted by provider for medical care or health care services rendered to a covered member which accurately contains information including, but not limited to:

- Patient’s name and date of birth
- Covered Member’s identification number
- Date(s) and place of service or purchase
- Services and supplies provided
- Diagnosis narrative ICD-9 code
- Procedure narrative or CPT-4 code
- Provider’s name, address and tax identification number
- Provider’s license number
- Provider’s charges
- Other information or attachments that may be mutually agreed upon by the parties in writing

Clinical Advisory Committee

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

Clinical Appeal

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

Commission on Accreditation of Rehabilitation Facilities (CARF)

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

Complaint

An oral or written expression of dissatisfaction by a provider, consumer or his/her representative.

Compliance*

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

Concurrent Review

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

Confidentiality

Entrusted [communication](#) of information which is considered [private](#) and implies an [ethical](#) or [legal principle](#). This type of information is not be not been made available or disclosed to unauthorized individuals, processes, or other entities.

Constructive Confrontation*

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

Continuous Quality Improvement (CQI)

An approach to quality management that builds upon traditional quality assurance methods by emphasizing the organization and systems. It focuses on the "process" rather than the individual, recognizes both internal and external "customers" and promotes the need for objective data to analyze and improve processes.

Contract Effective Date

The date the practitioner, group or facility joins the ValueOptions® of California health care system as an in-network or contracted provider.

Contracted Provider

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

Coordination of Benefits (COB)

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

Coordination of Care

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

Co-payment

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

Council on Accreditation (COA)

An international, independent, not-for-profit, child- and family-service and behavioral healthcare accrediting organization. Founded in 1977 by the Child Welfare League of America and Family Service America, COA partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

Covered Employee

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

Covered Services

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

Credentialing

The review process to determine if a practitioner, group, program or facility that has applied to participate in the ValueOptions[®] of California provider network meets criteria for inclusion.

Crisis Intervention

Treatment directed toward alleviation of an acute mental health or substance abuse condition by short-term intensive therapy to reduce impairment or disability. A rapid, intensive helping process that includes engaging the individual, assessment, building EAP participant support, contracting, follow-up and possibly referral to longer-term treatment.

Crisis Management Services

Intervention and coordination by individuals or teams before, during and after an event to resolve the crisis, minimize loss, and otherwise protect the organization and/or individual. It is a structured process of education and consultation to assist in easing the trauma and help to return personal control to the affected individual.

Critical Incident

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

Critical Incident Debriefing (CID)*

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

Cultural Competence

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

Current Procedural Technology (CPT)

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

Deductible

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

Dependent

In a payer's policy of insurance, a person other than the subscriber eligible to receive care because of a subscriber's contract.

Diagnosis (Dx)

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

Disciplinary Process*

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

Disenrollment

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

Drug Test*

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

Drug-Free Workplace Act*

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

DSM-IV-TR "V" Code

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

Dual Diagnosis

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

Duplicate Claim

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

Duty to Protect

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

Duty to Warn

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

EAP Plan

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

EAP Affiliate

A provider who has met ValueOptions® of California credentialing criteria for EAP affiliates and has entered into a currently effective agreement with ValueOptions® of California as an independent contractor or as part of a group contracted to provide EAP services to EAP participants.

EAP Assessment*

A structured process of observation and questions used by the EAP affiliate to identify, define and prioritize a participant's personal problems and concerns. Information from others, such as supervisors, family members, schools or other professionals treating the EAP participant, may be utilized in the assessment process if available. Assessment is a core component of the EAP scope of practice.

EAP Case Management*

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

EAP Case*

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

EAP Communication Plan

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

EAP Design*

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

EAP Feedback Mechanism*

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

EAP Follow-Up*

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

EAP Participant Satisfaction*

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

EAP Participant

See Covered Employee.

EAP Referral*

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

EAP Referral Types

Self-referral: an employee or eligible EAP participant requests EAP services.

Formal Referral: a “formal” recommendation is made by the work-site representative for an employee to access EAP services, with no potential job jeopardy for non-compliance. The referral is for an employee who is exhibiting job performance problems and the work-site representative is requesting feedback regarding an employee’s compliance with the EAP recommendations.

Mandatory Referral: a directive is given by the work-site for an employee to access EAP services with *potential job jeopardy* for noncompliance.

Regulatory Referral: is a referral with ties to state or federal regulatory guidelines, such as the Department of Transportation (DOT), Nuclear Regulatory Commission (NRC), etc... with *potential job jeopardy for noncompliance*.

EAP Supervisory Referral*

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

EAP Services

Those services provided to EAP participants in accordance with the professional and technical EAP standards adopted by and covered under the terms of a specific payer's plan.

EAP Service Plan

A written plan of action based on the assessment of the clients needs and strengths, that identifies the request for service, sets goals, describes a strategy for achieving these goals, and engages in joint problem-solving with the client.

EAP Short-term Problem Resolution*

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

EAP Supervisor/Union Training*

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

EAP Utilization Rate*

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

EAPA (Employee Assistance Professionals Association)

Established in 1971, the Employee Assistance Professionals Association (EAPA) is the world's oldest and largest membership organization for employee assistance professionals, with approximately 5,000 members in the United States and more than 30 other countries.

EDI: Electronic Data Interchange

The exchange of information between two systems in an electronic format

Electroconvulsive Therapy (ECT)

A treatment for depression that uses electricity to induce a seizure.

Eligibility

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

Emergency Medical or Behavioral Condition

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

Emergency Services and Care

Medically Necessary ambulance and ambulance transport services provided through the 911 emergency response system and those Covered Services provided for screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

Employee Assistance Professional Ethics

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

Employee Assistance Program (EAP)*

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

Employee Orientation*

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

Employment Retirement Income Security Act (ERISA) of 1974

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

Encounter

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

Equal Employment Opportunity*

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

Electronic Transport Server (ETS)

The ValueOptions[®] of California online service that enables users to upload files from their PCs.

Expedited or Urgent Grievance

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

Explanation of Benefits (EOB)

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

Fee for Service (FFS)

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

Fitness for Duty (FFD)

EAP term for an employer's determination of an employee's preparedness to work.

Fraud

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

Global Assessment of Functioning (GAF)

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

Grievance

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

Health and Human Services (HHS)

The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

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

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

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA was signed into federal law in 1996 (PL 104-191). The primary intent and purpose of this law was to protect health insurance coverage for workers and their families when they change or lose their jobs.

Hold Harmless

A requirement specifying that a provider is contractually responsible to hold the member harmless and not seek reimbursement from the member, other than co-payments or deductibles, for any changes incurred for service rendered, until after the entire provider appeals process is completed.

ICD-9

The ICD9 coding system is an international classification system which groups related disease entities and procedures for the purpose of reporting statistical information. Like the CPT, the purpose of the ICD9 is to provide a uniform language and thereby serve as an effective means for reliable nationwide communication among physicians, patients, and third parties.

Independent Medical Review (IMR)

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

Individually Identifiable

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

Inpatient Treatment Report (ITR)

A form used for authorization requests for inpatient and all alternative/higher levels of care.

Interactive Voice Response (IVR) (known as TeleConnect)

This system has two primary functions for certain accounts: (1) to register routine outpatient care (for certain accounts) and (2) to verify coverage for outpatient services and to obtain certification guidelines.

Joint Commission on Accreditation of HealthCare Organization (JCAHO):

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

Lack of Information (LOI)

The absence of information needed to make a medical necessity decision. If there is a Lack of Information (LOI) to make a medical necessity decision, as part of the Peer Review Process, ValueOptions® of California will notify the provider of the required information within specified timeframes depending on the type of request.

Language Assistance Program

The provision of services, materials, and information to members, free of cost, in a language that they speak and understand.

Last-chance Agreement*

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

Length of Stay

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

Level I Clinical Appeal

The process in which a member, member representative, or provider may submit any written comments, documents, records, or other relevant information in support of a requested appeal. A ValueOptions® of California staff member or committee investigates the substance of the appeal, including all aspects of clinical care involved and makes a decision regarding the original request for services. If the appeal involves a determination of no medical necessity, the Level I Clinical appeal decision is made by a ValueOptions® of California Peer Advisor who was not involved in the original determination of no medical necessity.

Level II Clinical Appeal

A process in which the member, member authorized representative, or the treating provider may request a Level II appeal if the original appeal (Level I) decision is upheld, in whole or in part, or if the original decision was overturned but medical necessity was not deemed to exist. This level of appeal involves a review of all pertinent information by a Level II appeal reviewer or committee who has not been previously involved with the adverse determination, depending on state law requirements or the member benefit plan. If the Level II Clinical Appeal involves a determination of no medical necessity, the Level II appeal reviewer is either a Peer Advisor or a Level II Clinical Appeal Committee made up of individuals not involved in any previous decision involving this request for services. When a Level II appeal has been filed, the member, member representative, or provider may submit any written comments, documents, records, or other documents in support of the appeal.

Level of Care

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

Lifetime Maximum

The maximum amounts that a plan will pay to cover a beneficiary's care during his/her lifetime.

Medical Review Officer*

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

Medically Necessary or Medical Necessity

Those services or supplies for the treatment of an active Mental Disorder or Substance Abuse Condition which, consistent with professionally recognized standards of practice, are determined by the ValueOptions® of California Medical Director or designee to be:

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

Medication Management Registration Form

A form used for requests for Medication Management services only. In service centers/contracts without TeleConnect capability, physicians register outpatient medication management services

with ValueOptions[®] of California by completing and sending/faxing a Medication Management Registration Form to the appropriate service center.

Member

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

Member Satisfaction Survey

ValueOptions[®] of California conducts a semi-annual member satisfaction survey. Results are summarized and distributed to the company's Corporate Quality Council (CQC) and other corporate departments, as well as service center Quality Management Committees. Corrective action plans, where appropriate, are developed at the service center level.

MemberConnect

A Web-based self-service alternative that compliments TeleConnect. It serves as a 24/7 one-stop shop for members who wish to complete everyday service requests online, such as checking benefits and reviewing claims status.

Mental Health or Substance Abuse Condition or Mental Disorder

A nervous or mental condition that is:

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

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 aligns mental health/substance abuse (MHSA) benefits and medical/surgical benefits for group health plans with more than 50 employees. The historic legislation of the Mental Health Parity Act makes the equal treatment of mental health and physical health an achievable reality.

National Committee on Quality Assurance (NCQA)

In January 1997, NCQA established accreditation standards for managed behavioral healthcare organizations (MBHO). Many ValueOptions[®] of California policies, procedures and quality

initiatives are driven or influenced by NCQA standards. Some of the quality indicators established by the NCQA are:

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

National Practitioner Database (NPDB)

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

National Provider Identifier (NPI)

A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services. The NPI is a single provider identifier that replaces the different identifiers used in standard electronic transactions. HHS adopted the NPI as a provision of HIPAA. The NPI Final Rule was published on January 23, 2004.

Negative Balance

The dollar amount over-paid for services rendered.

Newborn Child

A newborn child between birth and age 36 months.

NetworkConnect

An information technology system that supports all credentialing and network maintenance activities. Users leverage the application to effectively manage network provider file data, maintaining all information related to provider network participation. This application is for ValueOptions® of California internal use only.

Non-participating Provider

A practitioner, group practice, program or facility that is not contracted as participating in the ValueOptions® of California network.

Non-Certification

The non-certification constitutes a recommendation to the payer that services not be eligible for reimbursement under the health benefit plan. In those cases in which the provider has not demonstrated medical necessity for proposed or continuing services at a particular level of care, a non-certification decision is rendered by ValueOptions[®] of California.

Non-Compliant

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

Outcome Goals

Expected results related to employee assistance service delivery.

Out of Pocket Expense:

The sum of patient copayment and deductibles for a claim.

Out of Pocket Maximum:

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

Outpatient Psychological Testing Report (OPTR)

A ValueOptions[®] of California form used to preauthorize outpatient psychological testing, based on account-specific requirements.

Outpatient Review

A ValueOptions[®] of California form used to review outpatient mental health and/or substance abuse treatment for the review of medically necessary services. A provider is only required to submit the Outpatient Review when it is requested by a Clinical Care Manager.

Participating Provider or Provider

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

Peer Advisor (PA) or Peer Reviewer

A ValueOptions[®] of California licensed psychiatrist, licensed psychologist or master's-level licensed professional who provides peer reviews and clinical consultations on cases.

Pre-certification Review

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

Presenting Problem*

The personal concern or problem as described by the EAP participant prior to assessment by the EAP professional.

Prevention, Education and Outreach

Activities designed to assist members who exhibit, or who are at risk for developing, behavioral health disorders, with the goals of decreasing the incidence, prevalence, severity and/or residual effects of their illnesses and improving overall quality of life.

Primary Assessed Problem*

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

Problem Resolution*

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

Professional Development Hours (PDHs)*

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

Provider Appeals Committee

Providers have the right to appeal any adverse VOC Credentialing Committee decision regarding

network participation. ValueOptions® of California has established a Provider Appeals Committee (PAC) to hear provider appeals. This committee is comprised of representatives of major clinical disciplines, network providers and clinical representatives from corporate departments within ValueOptions® of California, none of whom compete with the appealing provider. Members of the PAC must not have participated in the original VOC Credentialing Committee decision under review.

Provider Dispute:

A formal written notice by a practitioner and/or facility/organizational provider to ValueOptions® of California challenging, appealing, or requesting reconsideration of a claim that has been denied, adjusted, or contested; seeking resolution of a billing determination or other contract dispute not related to network participation decisions; and /or disputing a request for reimbursement of an overpayment of a claim.

Provider Identification Numbers

Your **provider number** is your unique six digit number (e.g. 123456) which identifies you as a contracted provider. Your **vendor number** is a service location number where the service was rendered. You may have multiple vendor locations and each vendor location is given a five-digit number preceded by the letter 'A'. (e.g. A23456) If you do not have these numbers, contact our toll-free National Provider Line at **(800) 397-1630** during normal business hours Monday through Friday, EST for assistance.

Provider Sanctions

Though ValueOptions® of California is able to resolve most provider credentialing and quality issues through consultation and education, occasionally further action is necessary to ensure quality service delivery and protection of members. The VOC Credentialing Committee may impose provider sanctions for issues related to member complaints/grievances, quality of care or complaints of violations of state and federal laws and regulations. ValueOptions® of California will comply with all applicable local, state and federal reporting requirements regarding professional competence and conduct to ensure the highest quality of care for our members.

Provider Satisfaction Survey

ValueOptions® of California conducts an annual provider satisfaction survey to measure providers' opinions regarding ValueOptions® of California clinical and administrative processes. Data is aggregated, trended and used to identify improvement opportunities. Results are shared with providers through the CQC, Quality Management Committee, Clinical Advisory Committees, and provider newsletters. Corrective action plans, where appropriate, are managed through the Corporate Provider Relations Department and reported to the CQC.

ProviderConnect

A Web-based self-service alternative that compliments TeleConnect. It serves as a 24/7 one-stop shop for providers who wish to complete everyday service requests online. Providers can review claims electronically, review claims status, obtain copies of authorization letters, obtain forms and make changes to their provider profile.

Psychiatric Conditions

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

Psychological Testing

The use of one (1) or more standardized measurement instruments, devices, or procedures including the use of computerized psychological tests, to observe or record human behavior, and which require the application of appropriate normative data for interpretation or classification and includes the use of standardized instruments for the purpose of the diagnosis and treatment of mental and emotional disorders and disabilities, the evaluation or assessment of cognitive and intellectual abilities, personality and emotional states and traits, and neuropsychological functioning.

Quality Assurance/Improvement

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

Recredentialing

The review process to determine if a provider continues to meet the criteria for inclusion as a participating ValueOptions® of California EAP affiliate or participating provider.

Reduction in Force*

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

Reentry/Reintegration

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

ReferralConnect

A fully searchable online directory that displays a list of network providers and facilities throughout the country. Allows for multiple search criteria.

Release of Information

The legal form signed by an EAP participant or member allowing ValueOptions® of California to share specific information regarding the EAP participant or member with a specific person.

Requests for Additional Information

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

Retrospective Review

A review of the relevant portion of a medical record provided when permitted under the benefit plan in cases in which the patient has been discharged prior to the request for review.

Risk Management*

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

Safety-Sensitive Position*

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

Serious Chronic Condition

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

Serious Emotional Disturbances of Child

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

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

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

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

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

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

Service Area

The geographical area in which ValueOptions® of California is licensed to operate pursuant to the Knox-Keene Health Care Service Plan Act to operate the Health Plan.

ServiceConnect

This new application system that offers ValueOptions® of California customer service staff a state-of-the-art, interactive desktop interface. Representatives have immediate access to a member's complete ValueOptions® of California behavioral health service history. This application is for ValueOptions® of California internal use only.

Severe Mental Illness

Severe Mental Illness (SMI) includes the diagnosis and medically necessary treatment of the following conditions:

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

Sexual Harassment

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

Single Fixed Point of Accountability (SFPA)

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

Site Visits/Treatment Record Review

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

Special Investigations Unit (SIU)

ValueOptions® of California department responsible for reviewing and monitoring claims and billings by providers to ensure payment has been properly requested and made.

Stabilization

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

Submitter

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

Submitter ID

The ID that ValueOptions® of California assigns to uniquely identify the entity that is sending in electronic files, for one provider or multiple providers. Normally, we will use the Provider ID provided on the EDI electronic claims application and designate it as your Submitter ID. This may also sometimes be referred to your user ID or login ID.

Substance Abuse**

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

Surgery/Other Procedure

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

Taxonomy Code

The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct "levels" including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one value associated to them.

TeleConnect

An interactive voice response (IVR) system for members and providers enabling rapid, 24/7 self-service resolution of an array of common requests such as claims' status, authorizations, and forms.

Terminated or Disenrolled Provider

A provider whose contract with ValueOptions[®] of California is terminated, expires, or is not renewed.

Timely Filing

Network providers and EAP Affiliates are required to file invoices within ninety (90) days from the date the service was provided. No payment will be made for services billed later than ninety (90) days and, network providers and participating EAP Affiliates are prohibited from billing members for such services.

Topical Seminar

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

Uniform Billing Form/UB92 (CMS-1450) or HCFA-1450

The common claim form used by a hospital to bill for services rendered to a member. An electronic format of the CMS-1450 paper claim form that has been in general use since 1993.

Urgently Needed Services

Those services required to provide a diagnosis and treatment of a medical condition, of recent onset, that are not considered to be life threatening to the member but are of sufficient severity to necessitate prompt intervention. Urgent services are to occur within 48 hours.

Utilization Management (UM)

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

Utilization Review Accreditation Commission (URAC)

URAC, also known as the American Accreditation HealthCare Commission, is a non-profit charitable organization founded in 1990 to establish standards for the health care industry. URAC's first mission was to improve the quality and accountability of health care organizations using UR programs. In later years, URAC's mission expanded to cover a larger range of service functions found in various health care settings including the accreditation of integrated systems

such as health plans to smaller organizations offering specialty services. Now, in its 12th year of operation, URAC has a total of 13 accreditation programs.

ValueOptions®, Inc.

ValueOptions®, Inc. is a nation wide behavioral health care company and is the parent company of ValueOptions® of California, Inc.

ValueOptions® of California (VOC) Credentialing Committee

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

W-9 Form

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

Worker's Compensation*

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