

17: Glossary of Terms in Managed Care

Sources: Academy for Health Services Research and Health Policy, Glossary of Terms Commonly Used in Health Care, June 2002; www.cms.gov/glossary.

Appeal

The procedures for review of an adverse organizational determination regarding the health care services an enrollee believes he or she is entitled to receive or payment to be made by the enrollee for the service including internal reconsideration and external review.

Case Management

Services that address complicated medical and social needs in order to promote comprehensive coordinated care for identified populations. The Case Management program serves as an individualized service delivery based on comprehensive assessment tools that are used to develop a care plan. The care plan is developed in collaboration with the member, family (if applicable), and the treating physician. The goal is to empower the member and involve them in all aspects of the planning and service arrangements.

Centers for Disease Control and Prevention (CDC)

An agency within the U.S. Public Health Service that provides direction in the prevention and control of communicable and other threats to health, such as injury, environmental and occupational hazards, behavioral risks, and chronic diseases.

Centers for Medicare and Medicaid Services (CMS)

Formerly the Health Care Financing Administration (HCFA), CMS is the federal agency within the Department of Health and Human Services (DHHS) which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act).

Computed Axial Tomography (CAT) Scan

A form of diagnostic radiology.

Coordination of Benefits (COB)

Procedures used by insurers to avoid duplicate payment for medical expenses insured under more than one health insurance policy. Coordination of benefits prevents double payment by making one insurer primary and the other secondary, and assuring that not more than 100% of the cost is covered. Standard rules determine which payer is primary and which is secondary.

Copayment

The requirement that the health plan member pay some portion of medical expenses. Includes, copayments, deductibles, and coinsurance (paying a portion of the premium).

Durable Medical Equipment (DME)

Equipment, including assistive technology which a) can withstand repeated use; b) is used to service a health or functional purpose; c) is ordered by a qualified practitioner to address an illness, injury, or disability; and d) is appropriate for use in the home, school, or workplace.

Electronic Claim

A digital representation of a medical bill generated by a provider or provider's billing agent. Electronic claims are submitted by telecommunications to an insurance payer.

Emergency Medical Condition

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in:

- Placing the health of the individual in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child);
- Serious impairment to the individual's bodily functions; or
- Serious dysfunction of any bodily organ or part.

Encounter

A face-to-face contact between a patient and a health care provider for a health care service. An encounter is the basic unit of service used in collecting and analyzing utilization data.

Explanation of Benefits (EOB)

The document sent to a member by a health insurance plan for each medical claim. It spells out exactly how each claim was covered by the plan.

Fee-For-Service (FFS)

Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service provided.

Formulary

A list of drugs, usually by their generic names, and indications for their use. Providers are limited to prescribing only drugs listed on the health plan's formulary.

Health Plan Employer Data and Information Set (HEDIS)

A set of performance measures for health plans develop for the National Committee for Quality Assurance (NCQA).

Magnetic Resonance Imaging (MRI)

A form of diagnostic radiology.

Magnetic Resonance Angiography (MRA)

A form of diagnostic radiology.

National Committee for Quality Assurance (NCQA)

A national organization that accredits managed health care organizations and develops programs for assessing quality in managed health care.

Participating Provider

A provider under contract with a health plan. The provider agrees to accept the rules, terms, and fee schedule of a health plan. The health plan in turn agrees to certain terms related to providing information and payment.

Primary Care Provider (PCP)

A generalist physician (family practice, general internal medicine, general pediatrics) who provides primary care services, refers to specialty providers, and coordinates overall medical care.

Prior Authorization

Authorization from the health plan in advance of rendering a health or medical service.

Text Telephone (TTY)/Telecommunication Device for the Deaf (TDD)

Typewriter-like communications devices that permit individuals with speech and hearing disabilities to communicate by typing messages back and forth over telephone lines.