Insurance Glossary

Appeal:	A request to have a denial of coverage decision reviewed.
Appeal Process:	The process to request review of a decision. An appeal usually must be initiated within 180 days from the date of the initial non-authorization decision.
Authorization:	A basic "go ahead" from the insurance company to obtain treatment at a given facility. AUTHORIZATION IS NOT A GUARANTEE to pay.
Benefit:	The length/number of services allowed per year. For example, 10 inpatient days per year, 20 outpatient sessions per year.
Biological Based Diagnoses:	Such as major depression, PTSD, and anxiety disorders. Alcoholism and personality disorders, for example, are not biologically based.
Coinsurance:	Amount not covered by plan, which may be charged to a third party payer. If there is no third party payer, the member must pay this amount.
Designated Representative:	The member's attorney, guardian, or otherwise authorized representative.
Eligible:	Covered by insurance.
EOB or Explanation of Benefits:	Sent with payment to provider to indicate the dates of service paid. Often also sent to member as proof of payment.
Expedited Appeal:	An appeal of a denial when the member is still in treatment or has an Urgent Care Claim at the same level of care. A telephone appointment is set up between the provider and a Peer Reviewer who work for insurer.
Level of Care:	Type of mental health or substance abuse service, such as inpatient residential treatment or outpatient.
Medical Necessity:	Determining medial necessity is a complex process that includes consideration of the following: The requested services provide for the diagnosis or active treatment of a current mental disorder or chemical dependency. The treatment is consistent with the symptoms and the diagnosis. The type, level, and length of service and settings are within generally accepted standards for good medical practice within the organized medical community. The treatment is non-experimental. The treatment can be expected to improve member's condition or level of functioning. The treatment is rendered at the least restrictive level of care providing effective treatment of the disease or mental disorder. Treatment is provided by a licensed mental health professional.
Medical Review:	A review to determine if the mental health or substance abuse service is to be authorized for payment under the member's benefit plan.
Out of Pocket Maximum:	Amount paid in co-pay that exceeds level set in plan. For example, you may have a $200.00 out of pocket. If you reach that level, your insurance company may pay 100% of nay further charges.
Peer Reviewer/Case Manager:	A licensed clinician who works for an insurance company and reviews the authorization requests of providers.

Pre-Service Claim:	Requests for authorization of services made before those services are delivered.
Post-Service Claim:	Request for authorization of services made after those services have been delivered.
Provider:	A licensed mental health professional, such as a psychiatrist, clinical psychologist, clinical social worker, clinical nurse specialist, or marriage and family counselor.
Peer-to-Peer Conversation:	A telephone discussion with the provider and the Peer Reviewer who made the original denial decision to give an opportunity to have a peer-to-peer discussion regarding the decision to deny authorization of services.
Standard Written Appeal	The mandatory level of appeal that a member must complete prior to seeking other voluntary levels of appeal.
Urgent Care Claim	A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-0urgent care determinations (a) could jeopardize the life or health of the clamant or the ability of the claimant to regain maximal function or (b) in the opinion of a physician with knowledge of the claimant's medication condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Any claim that a physician with knowledge of the claimant's medication condition determines is a "claim involving urgent care" under this definition must be treated as an urged care claim by the plan. Absent a determination by the claimant's physician the determination of whether a claim involves urgent care is to be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.
UCR: Usual and Customary Rate	Contracted amount agreed to by the provider on which the insurance company bases its payment scale.