Definitions for Health Accreditation Standards

(NOTE: Defined terms appear in italics throughout the standards).

Being familiar with these definitions is critically important to accurate understanding of URAC Standards. In the Standards, defined terms are italicized. Readers are encouraged to refer to the definitions section each time they encounter an italicized term until they feel they have committed the meaning of that term to memory.

**Abandonment Rate:** The percentage of calls offered into a communications network or telephone system -- i.e., automatic call distribution (ACD) system of a call center -- that are terminated by the persons originating the call before answer by a staff person.

Interpretive note for term "Abandonment Rate": Abandonment rate is measured as the percentage of calls that disconnect after 30 seconds when an individual (live person) would have answered the call. For example, if there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended. (On ACD reports, monitor calls that "drop" after 30 seconds.)

**Access:** The consumer's or client's ability to obtain services in a timely manner.

Interpretive Note: The measures of access for consumers are determined by components such as the availability of services, their acceptability to the consumer, consumer wait time, and the hours of operation.

The measures of access for clients are determined by components such as turn-around time and other metrics as they may be defined in written business agreements, etc.

**Adverse Benefit Determination:** A decision by the Organization to deny or reduce a benefit for some or all of the lines of a claim (other than the application of a deductible or other cost-sharing).

**Adverse Event:** An occurrence that is inconsistent with or contrary to the expected outcomes of the Organization's functions.

**Advisory Board of Osteopathic Specialists (ABOS):** American Osteopathic Association (AOA) certification agent organized in 1939 for the purpose of establishing and maintaining standards of osteopathic specialization and pattern of training.

**American Board of Medical Specialties (ABMS):** Organized originally in 1933 as the Advisory Board of Medical Specialties, the ABMS (1970), in collaboration with the American Medical Association (AMA), is the recognized certifying agent for establishing and maintaining standards of medical specialization and pattern of training.

**Appeal:** A written or verbal request by a consumer, ordering provider or prescriber to contest an organizational determination (e.g., services have been denied, reduced, etc.).
Interpretive Note for term “Appeal”: Specific terms used to describe appeals vary, and are often determined by law or regulation.

Appeals Consideration: Clinical review conducted by appropriate clinical peers, who were not involved in peer clinical review, when a decision not to certify a requested admission, procedure, or service has been appealed. Sometimes referred to as “third level review.”

Assessment: A process for evaluating individual consumers that have been identified as eligible for a medical management program, such as disease management or case management, to identify specific needs relating to their clinical condition and associated co-morbidities.

Attending Physician: The doctor of medicine or doctor of osteopathic medicine with primary responsibility for the care provided to a patient in a hospital or other health care facility.

Attending Provider: The physician or other health care practitioner with primary responsibility for the care provided to a consumer.

Average Speed of Answer: The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a call center before answer by a staff person.

Interpretive note for term "Average Speed of Answer": The speed of answer is measured starting at the point when an individual (live person) would have answered the call. For example, if there is a pre-recorded message or greeting for the caller, the time it takes to respond to the call (i.e., average speed of answer) begins after the message/greeting has ended.

Benefit Calculation: An adjustment or calculation by the Organization of the financial reimbursement for a claim under the terms of the applicable benefit plan, provisions, criteria, provider contracts, or state rules.

Benefits Program: An arrangement to pay for health care services provided to a consumer. “Benefits program” includes, but is not limited to, health and medical benefits provided through the following organization types:

- Health maintenance organizations (HMOs);
- Preferred provider organizations (PPOs);
- Indemnity health insurance programs;
- Self-insured plans;
- Public programs, such as Medicare and Medicaid; and
- Workers’ compensation insurance programs.

Blockage Rate: The percentage of incoming telephone calls “blocked” or not completed because switching or transmission capacity is not available as compared to the total number of calls encountered. Blocked calls usually occur during peak call volume periods and result in callers receiving a busy signal.

Board-certified: A certification – approved by the American Board of Medical Specialties, the American Osteopathic Association, or another organization as accepted by URAC – that a physician has expertise in a particular specialty or field. To the extent that future URAC standards include other certifications, URAC will specify further approved boards.

Interpretive Note for term “Board-certified”: URAC recognizes that ABMS- and AOA-approved board
certifications may not be the only certification programs that may be acceptable for health professionals in URAC-certified organizations. For example, non-physician professionals will have appropriate certifications that are not ABMS- or AOA-approved. Any applicant wishing to have URAC recognize another board certification program should notify URAC early in the certification process. URAC will then take this recommendation to URAC’s Accreditation Committee.

The Accreditation Committee will review all requests, and will decide to approve or reject the certification. The Accreditation Committee will consider the following criteria in judging whether a certification is acceptable:

- Is the certification accepted within its target community of health professionals?
- Was the certification developed through an open, collaborative process?
- Does the certification reflect accepted standards of practice?
- Is the certification administered through an objective process open to all qualified individuals?

**Caller:** The consumer inquiring to obtain health care information. This may also be a representative inquiring on behalf of the consumer.

**Case:** A specific request for medical or clinical services referred to an organization for a determination regarding the medical necessity and medical appropriateness of a health care service or whether a medical service is experimental/investigational or not. It is a non-approval regarding medical necessity and medical appropriateness decisions for services covered under a health benefit plan’s terms and conditions or for coverage decisions regarding experimental or investigational therapies that is at issue during the independent review process.

**Case Involving Urgent Care:** Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations a) could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or b) in the opinion of a physician with knowledge of the consumer’s medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case. *(Note: This definition is derived from the Department of Labor’s definition of “claim involving urgent care.”)*

**Interpretive Note for term “Case Involving Urgent Care”:**
While the URAC standards are silent on the methods by which a claim is determined to be a “case involving urgent care,” the Department of Labor claims regulation (29 C.F.R. § 2560.503-1(m)(1)) specifies that whether a claim is a “claim involving urgent care” is to be determined by an individual acting on behalf of the health benefits plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is a “claim involving urgent care” shall be treated as a “claim involving urgent care.

**Case Management:** A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs using communication and available resources to promote quality cost-effective outcomes.
Certification:

1) (UM Specific Definition) A determination by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Interpretive Note for term “Certification”: “Determination” may vary depending on context.

2) (General Definition) A professional credential, granted by a national organization, signifying that an individual has met the qualifications established by that organization. To qualify under these standards, the certification program must:

- Establish standards through a recognized, validated program;
- Be research-based; and
- Be based (at least partially) on passing an examination

Claim: Any bill, claim, or proof of loss made by or on behalf of a consumer or health care provider to an Organization (or its intermediary, administrator, or representative) for which the consumer or health care provider has a contract for payment of health care services. (Note: definition based on Code of Virginia § 38.2-3407.15.)

Claimant: A person or entity who submits a claim, or on whose behalf a claim is submitted. (Includes “consumer” for URAC’s Core Standards.)

Claims Administrator: Any entity that recommends or determines to pay claims to enrollees, physicians, hospitals, or others on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third party administrators, or other private contractors.

Claims Processing Organization: An organization that seeks accreditation under these standards. Examples of organizations that process claims include but are not limited to:

- Health insurance companies;
- Health maintenance organizations (HMOs);
- Preferred provider organizations (PPOs);
- Third-party administrators (TPAs);
- Disability insurance carriers; and
- Workers’ compensation insurance carriers.

Interpretive Note for term “Claims Processing Organization”: Throughout this document the term “organization” refers to claims processing organization.

Clean Claim: A claim that has no material defect, impropriety, lack of any required substantiating documentation, or special circumstance(s) – such as, but not limited to, coordination of benefits, pre-existing conditions, subrogation, or suspected fraud – that prevents timely adjudication of the claim.

Clean Credentialing File: A credentialing application is considered “clean” if it meets the following criteria:

- The provider has completed all applicable sections of the credentialing application.
- Where indicated, the provider has signed, initialed and dated the credentialing application.
- All necessary supporting documentation has been submitted and is included with the credentialing application in the provider’s file.
- Credentials verification reveals that there are no issues to report to the credentialing committee as defined in the organization’s credentialing plan. At a minimum, URAC considers the following items to be “issues” for any credentialing application:
  - Any lapse in practice greater than six (6) months*
  - Any history of malpractice claims or settlement*
5. The provider meets the credentialing criteria approved by the credentialing committee and as stated in the credentialing plan.

**Client:** A business or individual that purchases services from the Organization.

**Interpretive Note for term “Client”:** Here are some examples of client relationships:

- If a health plan provides health coverage to an employer, the employer is the client.
- If a health plan contracts for utilization management services from a utilization management organization, the health plan is the client.
- If a PPO contracts for credentialing services with a CVO, the PPO is the client.

**Clinical Activities:** Operational processes related to the delivery of clinical triage and health information services performed by clinical staff.

**Clinical Decision Support Tools:** Protocols, guidelines, or algorithms that assist in the clinical decision-making process.

**Clinical Director:** A health professional who: (1) is duly licensed or certified; (2) is an employee of, or party to a contract with, an organization; and (3) who is responsible for clinical oversight of the utilization management program, including the credentialing of professional staff and quality assessment and improvement functions.

**Clinical Peer:** A physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider.

**Clinical Practice Guidelines:** Systematically developed statements to assist decision-making about appropriate health care for specific clinical circumstances.

**Clinical Rationale:** A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the patient’s condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

**Clinical Review Criteria:** The written screens, decision rules, medical protocols, or guidelines used by the organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health benefit plan.

**Clinical Staff:** Employees or contracted consultants of the health care organization who are clinically qualified to perform clinical triage and provide health information services.

**Clinical Triage:** Classifying consumers in order of clinical urgency and directing them to appropriate health care resources according to clinical decision support tools.

**Comparable:** Data about performance is compared to an historical baseline (which may be internal) and ongoing...
progress is recorded in regular intervals (e.g., monthly, quarterly, or annually). External benchmarks also may be used for purposes of comparison.

**Complaint:** An expression of dissatisfaction by a consumer expressed verbally or in writing regarding an organization’s products or services that is elevated to a complaint resolution system.

**Interpretive Note for term “Complaint”:**
- This term is sometimes referred to as “grievance.”
- This definition does not include appeals.

**Concurrent Review:** Utilization management conducted during a patient's hospital stay or course of treatment (including outpatient procedures and services). Sometimes called "continued stay review".

**Condition:** A diagnosis, clinical problem or set of indicators such as signs and symptoms that an individual consumer may have that define him or her as eligible and appropriate to participate in a medical management program such as a disease management or case management program.

**Conflict of Interest:** Any relationship or affiliation on the part of the organization or a reviewer that could compromise the independence or objectivity of the independent review process. Conflict of interest includes, but is not limited to:
- An ownership interest of greater than 5% between any affected parties;
- A material professional or business relationship;
- A direct or indirect financial incentive for a particular determination;
- Incentives to promote the use of a certain product or service;
- A known familial relationship;
- Any prior involvement in the specific case under review.

**Consumer:** An individual person who is the direct or indirect recipient of the services of the Organization. Depending on the context, consumers may be identified by different names, such as “member,” enrollee, “beneficiary,” “patient,” “injured worker,” “claimant,” etc. A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the Organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.

**Interpretive Note for term “Consumer”:**
In the case of a consumer who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the consumer behalf may be a consumer for the purposes of these standards.

**Contractor:** A business entity that performs delegated functions on behalf of the Organization.

**Interpretive Note for term “Contractor”:**
For the purposes of these standards, the term “contractor” includes only those contractors that perform functions related to the key processes of the Organization. It is not URAC’s intent to include contractors that provide services unrelated to key processes. For example, a contractor that provides catering services would not fall within the definition of “contractor” in these standards. Conversely, a company that provides specialty physician reviewers to a UM organization would clearly fall within the definition of “contractor.”

**Covered Benefits:** The specific health services provided under a health benefits program, including: cost-sharing and other financial features; claims submission and reimbursement processes; requirements and processes (if any) for prior authorization or other approval of health services.

**Covered Service:** A health care service for which reimbursement or other remuneration is provided to a consumer or on behalf of a consumer under the terms of the consumer’s benefits program.
Credentials Verification: A process of reviewing and verifying specific credentialing criteria of a practitioner.

Credentials Verification Organization (CVO): An organization that gathers data and verifies the credentials of health care practitioners.

Criteria: A broadly applicable set of standards, guidelines, or protocols used by the organization to guide the clinical processes. Criteria should be:

- Written;
- Based on professional practice;
- Literature-based;
- Applied consistently; and
- Reviewed, at a minimum, annually.

Data Integrity: The quality or condition of being accurate, complete and valid, and not altered or destroyed in an unauthorized manner.

Date of Receipt: The date on which a claim arrives at an Organization (or, for claims that arrive on a non-business day, the date of the first business day thereafter).

Delegation: The process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate.

Discharge Planning: The process that assesses a patient’s needs in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge or transfer from current services or level of care.

Disease Management (DM): According to the Disease Management Association of America, “Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management: supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health. Disease management components include: population identification processes; evidence-based practice guidelines; collaborative practice models to include physician and support-service providers; patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance); process and outcomes measurement, evaluation, and management; routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling.”

Disease Management Program: A program or entity that provides the scope of functions and activities necessary to provide disease management.

Electronic: Mode of electronic transmission including the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media. (Final Rule, Department of Health and Human Services, “Health Insurance Reform: Standards for Electronic Transactions,” Federal Register (Aug. 17, 2000).)

Electronic Health Record: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.
Electronic Medical Record: An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

Engagement: Proactive outbound contact with consumers, by phone or mail, within some specified time frame of identification of eligible consumers, with tracking of interactions.

Evidence-based: Recommendations based on valid scientific outcomes research, preferably research that has been published in peer reviewed scientific journals. Evidence-based information can be used to develop protocols, pathways, standards of care or clinical practice guidelines and related educational materials.


Expedited Appeal: An appeal of a non-certification of a case involving urgent care. See definition of "Case Involving Urgent Care."

Facility: An institution that provides health care services.

Facility Rendering Service: The institution or organization in or by which the requested admission, procedure, or service is provided. Such facilities may include, but are not limited to: hospitals; outpatient surgical facilities; individual practitioner offices; rehabilitation centers; residential treatment centers; skilled nursing facilities; laboratories; imaging centers; and other organizational providers of direct services to patients.

Family: Individuals whom the consumer chooses to involve in the decision-making process regarding the consumer’s health care. In the case of a consumer who is unable to participate in the decision-making process, “family” shall include any individual legally authorized to make health care decisions on the consumer’s behalf.

Health Assessment Tool: A data collection instrument that allows a consumer and the organization to ascertain the consumer’s health status and health risks. Such tools are often administered online, although other formats are permissible. Other common terms used to describe health assessment tools are “health risk assessment” and “health survey.”

Health Benefits Plan: An arrangement to pay for medical services provided to a consumer. “Health benefits plan” includes (but is not limited to):

- HMOs;
- PPOs;
- Indemnity health insurance programs;
- Self-insured plans;
- Public programs, such as Medicare and Medicaid; and
- Workers’ Compensation insurance programs.

Health Care Team: The attending physician and other health care providers with primary responsibility for the care provided to a consumer.

Health Content Reviewer: An individual who holds a license or certificate as required by the appropriate jurisdiction in a health care field (where applicable), has professional experience in providing relevant direct patient care or has completed formal training in a health-related field.

Health Education: Educational resources designed to enhance the knowledge and understanding of health
topics to promote wellness and self-care.

**Health Information:** Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.

**Health Information Exchange:** The electronic movement of health-related information among organizations according to nationally recognized standards.

**Health Information Organization:** An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

**Health Literacy:** The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate decisions regarding their health.

**Health Professional:** An individual who: (1) has undergone formal training in a health care field; (2) holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and (3) has professional experience in providing direct patient care.

**Health-Related Field:** A professional discipline that promotes the physical, psychosocial, or vocational well being of individual persons.

**Individually Identifiable Information:** Any information that can be tied to an individual consumer, as defined by applicable laws.

**Independent Review:** A process, independent of all affected parties, to determine if a health care service is medically necessary and medically appropriate, experimental/investigational or to address administrative/legal issues. Independent review typically (but not always) occurs after all appeal mechanisms available within the health benefits plan have been exhausted. Independent review can be voluntary or mandated by law.

**Independent Reviewer:** The individual (or individuals) selected by the organization to consider a case. Selection of the reviewer(s) for a case must be conducted in accordance with standards IR 1 and IR 6. All reviewer(s) who are health care practitioners must have the following qualifications:

- Active licensure;
- Recent experience or familiarity with current body of knowledge and medical practice;
- At least 5 years experience providing health care;
- If the reviewer is an M.D. or D.O., board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association;
- If the reviewer is a D.P.M., board certification by the American Board of Podiatric Surgery.

**Initial Clinical Review:** Clinical review conducted by appropriate licensed or certified health professionals. Initial clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to peer clinical review for certification or approval.
non-certification. Sometimes referred to as “first level review.”

Interoperability: Ability of two or more systems or components to exchange information and to use the information that has been exchanged.

Knowledge Domains – Areas of specific expertise.

License: A license or permit (or equivalent) to practice medicine or a health profession that is 1) issued by any state or jurisdiction in the United States; and 2) required for the performance of job functions.

Interpretive Note for term "License":

In this definition, the word “equivalent” includes certifications, registrations, permits, etc. Specific terms will vary by state and health profession.

Medical Director: A doctor of medicine or doctor of osteopathic medicine who is duly licensed to practice medicine and who is an employee of, or party to a contract with, an organization, and who has responsibility for clinical oversight of the organization’s utilization management, credentialing, quality management, and other clinical functions.

Medical Management – A general term encompassing activities such as utilization management, case management, and the clinical aspects of quality management.

Medication Reconciliation: The process of creating the most accurate list possible of all medications a patient is taking - including drug name, dosage, frequency, and route - and comparing that list against the physician’s admission, transfer and/or discharge orders, with the goal of providing correct medications to the patient at all transition points.

Note for term "Medication Reconciliation": This definition comes from the Institute for Healthcare Improvement (IHI), Reconcile Medication at All Transition Points, available through the following Web site: www.ihi.org.

Non-Certification: A determination by an organization that an admission, extension of stay, or other health care or pharmacy service has been reviewed and, based on the information provided does not meet the clinical requirements for medical necessity, appropriateness, or effectiveness under the applicable health benefit plan.

Non-Clinical Administrative Staff: Staff who do not meet the definition of health professional (including intake personnel).

Non-Clinical Staff: Employees or contracted consultants of a health care organization who do not perform clinical assessments or provide callers with clinical advice. They may be responsible for obtaining demographic information, providing benefit information, and re-directing callers.

Off-shoring: The relocation of an organizational function to a foreign country under the same organizational control (ownership).
Note related to off-shoring: In health care management, outsourcing distinct functions to a foreign subcontractor is the more common trend. See the definition for "outsourcing."

Opt-in: Affirmative consent actively provided by a consumer to participate in an activity or function of the program, provided after the program has fully disclosed the terms and conditions of participation to the consumer.

Note for term "Opt-in": Auto enrollees are not considered "opt-in" enrollees of the program.

Opt-out: A process by which an enrolled consumer declines to participate in an activity or function of the program.

Ordering Provider: The physician or other provider who specifically prescribes the health care service being reviewed.

Organization: A business entity that seeks accreditation under these standards.

Interpretive Note for term “Organization”: This can include a program or department and can be geographically defined.

Organizational Conflict of Interest: A conflict that affects objectivity between the organization’s financial interests and the organization’s obligations to the client.

Outcome: A consumer’s health status following services.

Outsourcing: The delegation of services or functions from internal production to an external entity outside of the United States.

Oversight: Monitoring and evaluation of the integrity of relevant program processes and decisions affecting consumers.

Participant (participating): An eligible consumer or treating provider that has had one or more inbound or outbound contacts with the disease management program, and if a consumer, has not opted out of the program.

Participating Provider – A provider that has entered into an agreement with the organization to be part of a provider network.

Patient: The enrollee or covered consumer for whom a request for certification may or may not have been filed.

Interpretive Note for term “Patient”: In the case of a patient who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the patient’s behalf may be a patient for the purposes of these standards.

Peer Clinical Review: Clinical review conducted by appropriate health professionals when a request for an admission, procedure, or service was not approved during initial clinical review. Sometimes referred to as “second level review.”

Peer-to-Peer Conversation: A request by telephone for additional review of a utilization management determination not to certify, performed by the peer reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.

Personal Health Record: An electronic record of health-related information on an individual that conforms to
nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

**Personally-identifiable Information:** Any information that can be tied to an individual identifier.


**Plain Language:** Communication that uses short words and sentences, common terms instead of (medical) jargon, and focuses on the essential information recipients need to understand.

**Population:** Depending on the model of the disease management program, the population for which it is responsible may be all of the consumers identified with the disease condition, or the population may be only those consumers identified to the disease management program by client referral or another mechanism. In some instances the disease management program may be responsible for identification of the population, and in other instances the client may conduct identification (and stratification) activities.

**Potential Enrollees:** Employees and eligible dependents of employer/purchasers who are offering enrollment in the organization’s products as part of the employee benefits package. In the case of organizations that offer products in the individual market, potential enrollees include individuals from the general public in the geographic area where the organization offers the products.

**Practitioner** – An individual person who is licensed to deliver health care services without supervision.

**Pre-Review Screening:** Automated or semi-automated screening of requests for authorization that may include: (1) collection of structured clinical data (including diagnosis, diagnosis codes, procedures, procedure codes); (2) asking scripted clinical questions; (3) accepting responses to scripted clinical questions; and (4) taking specific action (certification and assignment of length of stay explicitly linked to each of the possible responses). It excludes: (1) applying clinical judgment or interpretation; (2) accepting unstructured clinical information; (3) deviating from script; (4) engaging in unscripted clinical dialogue; (5) asking clinical follow-up questions; and (6) issuing non-certifications.

**Primary Physician:** The physician who is primarily responsible for the medical treatment and services of a consumer.

**Primary Source Verification:** Verification of a practitioner’s credentials based upon evidence obtained from the issuing source of the credential. Also known as "Primary Source."

**Principal Reason(s):** A clinical or non-clinical statement describing the general reason(s) for the non-certification determination ("lack of medical necessity" is not sufficient to meet this).

**Professional Competency:** The ability to perform assigned professional responsibilities.

**Prospective Review:** Utilization management conducted prior to a patient’s admission, stay, or other service or course of treatment (including outpatient procedures and services). Sometimes called "precertification review" or "prior authorization."
**Protected Health Information:** Individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in any medium described in the definition of electronic media at Sec. 162.103 of this subchapter; or (iii) Transmitted or maintained in any other form or medium. (2) Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer. (67 Fed. Reg. at 53,267 (Aug. 14, 2002); 65 Fed. Reg. at 82,805 (Dec. 28, 2000) (to be codified at 45 C.F.R. pt. 164.501)).

**Provider:** A licensed health care facility, program, agency, or health professional that delivers health care services.

**Provider Network** – A group of providers with which the organization contracts to provide health services to consumers.

**Provider-Specific Information:** Information that is sufficient to allow identification of the individual provider.

**Quality Improvement Project:** An organization-wide initiative to measure and improve the service and/or care provided by the organization.

**Quality Management (QM) program:** A systematic data-driven effort to measure and improve consumer and client services and/or health care services.

**Quality Review Study:** A scientific and systematic measurement of the effects or results of treatment modalities or practices for a particular disease or condition. The goal of quality measurement is to improve health care services by monitoring and analyzing the data and modifying practices in response to this data.

**Rationale:** The reason(s) or justification(s) – commonly based on criteria – for a specific action or recommendation.

**Re-assessment:** Re-evaluation of an individual consumer participating in a medical management program, such as disease management or case management, on a specified frequency using the same or similar tools that were used in the initial assessment. Re-assessment may also include re-stratification.

**Referring Entity:** The organization or individual that refers a case to an organization. Referring entities may include insurance regulators, health benefits plans, consumers, and attending providers. Some states may limit by law which individuals or organizations may be a referring entity.

**Regional Health Information Organization:** A health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.

**Retrospective Claim:** A claim presented after services have been provided (i.e., a post-service claim) and presented for consideration under a contract or policy.

**Retrospective Review:** Review conducted after services (including outpatient procedures and services) have been provided to the patient.

**Interpretive Note for term “Retrospective Review”:** Retrospective medical necessity determinations are considered utilization management (and subject to these standards).
Review of Service Request: Review of information submitted to the organization for health care services that do not need medical necessity certification nor result in a non-certification decision.

Reviewer(s): The individual (or individuals) selected by the organization to consider a case. Selection of the reviewer(s) for a case must be conducted in accordance with standards IR 1 and IR 6. All reviewer(s) who are health care practitioners must have the following qualifications:

- Active licensure;
- Recent experience or familiarity with current body of knowledge and medical practice;
- At least 5 years experience providing health care;
- If the reviewer is an M.D. or D.O., board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.
- If the reviewer is a D.P.M., board certification by the American Board of Podiatric Surgery.

Second Opinion: Requirement of some health plans to obtain an opinion about the medical necessity and appropriateness of specified proposed services by a practitioner other than the one originally making the recommendation.

Secondary Source Verification or Secondary Source: Verification of a practitioner’s credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential (e.g., copies of licenses and certifications and data base queries).

Service Requests: Screening callers to determine the services that are necessary at the time of the call. This is usually performed by a non-clinical staff person to determine if the call is clinical and requires transfer to a clinical staff person.

Staff: The Organization’s employees, including full-time employees, part-time employees, and consultants.

Standard Appeal: An appeal of a non-certification that is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. However, standard appeals may also include secondary appeals of expedited appeals.

Statistically valid: Based on accepted statistical principles and techniques.

Stratification: A process for sorting a population of eligible consumers into groups relating to the need for disease management interventions. Stratification and assessment are inter-related, and both provide data used to assign interventions. Stratification may use a variety of data sources, including but not limited to claims, pharmacy, laboratory, or consumer-reported data.

Structured Clinical Data: Clinical information that is precise and permits exact matching against explicit medical terms, diagnoses or procedure codes, or other explicit choices, without the need for interpretation.

Therapeutic: Of or relating to the treatment of disease or disorders by remedial agents or methods.

Treating Provider: The treating provider is the individual or provider group who is primarily managing the treatment for a consumer participant in the disease management program. The treating provider is not necessarily the consumers’ primary care physician. The consumer may have a different treating provider for different conditions.

Urgent Care: See "Case Involving Urgent Care."

Utilization Management (UM): Evaluation of the medical necessity, appropriateness, and efficiency of use of
health care services, procedures, and facilities. UM encompasses prospective, concurrent and retrospective review in which clinical criteria are applied to a request. UM is sometimes called "utilization review".

**Worker:** An ill or injured individual (or representative acting on behalf of the worker) who is eligible for workers’ compensation benefits and who files for, or for whom a workers’ compensation claim has been filed.

**Written Agreements:** A document – including an electronic document – that specifies the terms of a relationship between the Organization and a client, consumer, or contractor. This term may include a contract and any attachments or addenda.

**Written Notification:** Correspondence transmitted by mail, facsimile, or electronic medium.

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 (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual. (65 Fed. Reg. at 82,804 (to be codified at 45 C.F.R. pt. 164.501))

*(Note: This definition is derived from the federal Health Insurance Portability and Accountability Act (HIPAA)).*