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| Utilization Management Program: Glossary of Terms |  |
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\* Indicates URAC definition

**Administrative Non-Certification:** Non-Certification of a requested service due to a lack of information otherwise known as Lack of Information denial.

**\*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 services has been appealed. Sometimes referred to as “third level review.”

**\*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 the physician with knowledge of the consumer’s medical condition, would subject the consumer to severe pain that cannot be adequately managed with the care or treatment that is the subject of the case.

**\*Clinical Peer:** A physician or other health professional who holds an active, unrestricted license to practice medicine or a health profession in a state or territory of the United States. 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 or is a Doctor of Medicine or Doctor of Osteopathic Medicine. Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting a peer clinical review. The Medical Director will determine the peer reviewer is qualified to render a clinical opinion about the medical condition, procedures, and treatment under review.

**\*Concurrent review:** Utilization management conducted during a patient’s hospital stay or course of treatment (including inpatient and outpatient services). Sometimes called “continued stay review”.

**Coverage denial:** Determination that a service, treatment, drug or device is specifically limited or excluded under the health benefit plan

**\*Expedited appeal**: An appeal of a non-certified case involving urgent care.

**\*Initial screening** (pre-review screening and/or scripted clinical 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; (6) issuing non‑certifications; and (7) verification of insurance coverage or eligibility.

**Insufficient Information:** Some information is received, but it is inadequate to make a determination.

**Lack of Information:** No information is received, that is, there is a total absence of information on which to base a determination.

**\*Non-certification:** A determination by an organization (Payer Compass Medical Director or IRO) 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.

**\*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.” Payer Compass may refer to this level of review as a “Peer to Peer” or “MD 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.

**\*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”, prospective review can include prospective prescription drug utilization.

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

**\*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.

**\*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 to 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.

**\*Utilization Management:** Evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. Utilization Management encompasses prospective, concurrent, and retrospective review, as well as any review of services where authorization is required in which clinical criteria are applied to a request. UM is sometimes called “utilization review”.