

MCQA Glossary

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Access Plans (WC Network and Health)

An action plan filed with the Texas Department of Insurance for approval by the Commissioner as received from a Health Maintenance Organization (HMO) and/or Workers' Compensation Network (WCN). The plan establishes arrangements for healthcare in previously approved or proposed service areas in which the HMO or WCN does not have an adequate number of contracted physicians, providers, or facilities.

Adverse Determination

A determination by a utilization review agent that health care services provided, or proposed to be provided, to a patient are not medically necessary, or are experimental or investigational.

*For Workers' Compensation, a determination by a utilization review agent that the health care services provided, or proposed to be provided, to an injured employee are not medically necessary.

Appeals - WC and Health

A formal process by which a utilization review agent offers a mechanism to dispute adverse determinations. Known as reconsideration for WC.

Balance Billing

Any or all of a claim that was not paid by the HMO that is billed to the enrollee.

Carrier

An entity that contracts with a provider, physician, employer, enrollee, or injured employee for health care services.

Case Manager

A person who has training, experience, and responsibility for coordinating and assisting in the provision under a health benefit plan for an enrollee/injured employee to ensure the delivery of necessary and appropriate care on a timely basis as required by/for the medical condition.

For Workers' Compensation Networks, a case manager must be certified by an established accrediting organization in at least one of the following: medical case management, case management administration, rehabilitation case management, continuity of care, disability management, or occupational health.

A claims adjuster may not serve as a case manager.

Catastrophic Event

An event, including acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, windstorm, flood, or organized labor stoppages, that cannot reasonably be controlled or avoided and that causes an interruption in the claims submission or processing activities of an entity for more than two consecutive business days.

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Certified Network

A health care delivery system that is composed of contracted physicians and providers for the purpose of delivering necessary medical care and health care services to injured employees. A health care delivery system that is composed of contracted physicians and providers for the purpose of delivering necessary medical care and health care services to injured employees.

Children's Health Insurance Program-(CHIP)

A medical assistance program established under state or federal law. Eligibility requirements are determined by the Health and Human Services Commission (HHSC) for children between the ages of 0-18.

Co-insurance

The percent of each health care bill you must pay out of your own pocket. Non-covered charges and deductibles are in addition to this amount.

Compensable Injury

An illness or injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle.

Concurrent Review

A review of ongoing health care to determine medical necessity of an extension of ongoing emergency care or previously authorized health care.

Consumer Choice Health Benefit Plans

A health benefit plan that has required disclosures to show reduced premiums and cost savings that are not required to provide all state-mandated health benefits.

- To access and view the checklist for a Large Employer Consumer Choice Benefit Plan, use the following link:
<https://www.tdi.texas.gov/forms/lhlhmo/hmo002.pdf>
- To access and view the checklist for a Small Employer Consumer Choice Benefit Plan, use the following link:
<https://www.tdi.texas.gov/forms/lhlhmo/hmo003.pdf>
- To access and view the checklist for an Individual Consumer Choice Benefit Plan, use the following link:
<https://www.tdi.texas.gov/forms/lhlhmo/hmo001.pdf>

Cooperatives

A corporation established to make health care coverage available to small and large employers and their eligible employees and the eligible employees' dependents. The groups joining to form a cooperative must be similar in the nature of business.

Copayment

A specified dollar amount described in the schedule of benefits that must be paid by an enrollee to the provider when they receive covered services.

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Deductible

A specified dollar amount of expenses as described in the schedule of benefits that must be incurred and paid by the enrollee before health plan benefits are payable.

Delegation

The process by which an entity (either a person or a group) has been contractually appointed to perform certain functions on behalf of another.

Designated Doctor

A physician or provider who has successfully completed TDI Workers' Compensation Division approved training and examination on the assignment of impairment ratings, medical causation, extent of injury, functional restoration, return to work, and other disability management topics and must be fully authorized to certify maximum medical improvement (MMI).

Emergency Care (HMO)

Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson to believe that the individual's condition if left untreated could place their health in serious jeopardy, impair bodily functions, or result in serious disfigurement, and for a pregnant woman, result in serious jeopardy to the health of the fetus. Emergency care also pertains to behavioral health services.

Emergency - Medical (WCN)

The sudden onset of a medical condition manifested by acute symptoms, including severe pain, that in the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part. Medical emergency also pertains to behavioral health services.

Enrollee

A person who is covered by a health benefit plan.

ERISA

An Act signed into law in 1974 as the Employees Retirement Income Security Act to protect the interest of employee benefit plan participants and their beneficiaries by requiring certain financial disclosures, standards of conduct, and by providing for appropriate remedies and access to the federal courts. ERISA does not require employers to establish pension plans or provide health insurance coverage to their employees or retirees; however, it does regulate the operation of a pension plan or health insurance benefit plan if the employer chooses to establish one or both.

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Fully Insured Plan

A health benefit plan in which an employer contracts with an HMO/carrier to pay health care claims based on the benefits purchased for a monthly premium. Covered employees may be responsible for deductibles and/or copayments, if applicable.

Geographic Service Area

Area within which direct service benefits are available and accessible to HMO enrollees who live, reside, or work within that geographic area.

Health Care Provider (HCP)

Could be either a physician or provider as defined below:

- Physician - An individual licensed to practice medicine in this state and regulated by the Texas Medical Board.
- Provider - A person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state and regulated by the agency that issues the license (e.g. Board of Nurse Examiners, Board of Chiropractic Examiners, etc.), including: a chiropractor, registered nurse, pharmacist, optometrist, registered optician, or acupuncturist; or a pharmacy, hospital, or other institution or organization.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data.

Hold Harmless

A mandatory contractual provision between a health maintenance organization (HMO) and a physician or provider that prohibits the physician or provider from billing the enrollee for the cost of covered health care services if the HMO does not pay the physician or provider for those services. However, the physician or provider may bill the enrollee for any co-payments, co-insurances, or non-covered services specified in an enrollee's benefit plan.

Independent Review Organization (IRO)

An entity that is certified by the commissioner to conduct reviews under the authority of the Chapter 4202, <http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.4202.htm#4202.001.00>, Texas Insurance Code, and related rules. By law, an IRO must not be affiliated with the insurance carrier or HMO which has denied a request for authorization for proposed treatment. IROs perform an administrative review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to a Texas resident which has been denied twice as not medically necessary or not appropriate.

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Injured Employee

An employee that has sustained an injury within the course and scope of employment.

Justified Complaints

A complaint is justified if there is an apparent violation of a policy provision, contract provision, rule or statute, or if there is a valid concern that a prudent layperson would regard as a practice or service that is below customary business or medical practice standards.

Large Group Employer

A person or entity who employed an average of at least 51 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. For purposes of this definition, a partnership is the employer of a partner.

Medicaid

A state and federally funded health care coverage program that is available to eligible residents of the state. The Medicaid program is managed and monitored by the Health and Human Services Commission (HHSC) of the State of Texas. Additional information is available at the following website:

<http://www.hhsc.texas.gov>

Medicare Advantage

A health care coverage offered to eligible recipients of Medicare for an additional premium. The Medicare Advantage plans are offered by managed care health plans and may include more benefits than the standard Medicare benefit package. Some Medicare Advantage plans will provide prescription benefits as part of their coverage which would not be available in the standard Medicare plan without enrolling in Part D.

Medicare Advantage Plans

This plan is considered a total replacement of the traditional Medicare coverage, and enrollees are required to follow all plan requirements such as using only the providers available on the plan's provider directory and obtaining referrals prior to seeing a specialist. Additional information is available at the following website:

<http://www.cms.gov/>.

Medicare Supplement

A health care coverage that is offered to eligible recipients of Medicare for an additional premium. A Medicare Supplement plan is *not* a total replacement of traditional Medicare coverage. This coverage is in addition to the traditional Medicare coverage and may assist enrollees in paying for co-payments and deductibles that are not covered by Medicare. Additional information is available at the following website: <http://www.cms.gov/>.

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National Provider Identifier (NPI)

A unique identifier that is used by one physician or provider on all health care forms. Each provider can contact the Center for Medicaid and Medicare Services (CMS) at the following website to submit their application for their NPI number:

<http://www.cms.gov/>

Network - Workers' Compensation Health Care

A health care delivery system composed of physicians or providers that have contracted to provide services to injured employees of an employer who has elected to contract with a health care network. A certified workers' compensation health care network is an organization that is:

- Formed as a health care provider network to provide or arrange to provide health care services to injured employees;
- Required to be certified in accordance with Texas Insurance Code Chapter 1305, <http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1305.htm>, Texas Administrative Code Chapter 10, [https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=4&ti=28&pt=1&ch=10](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=28&pt=1&ch=10), and other rules of the commissioner as applicable; and
- Established by, or operating under contract with, an insurance carrier.

Network - Health Maintenance Organization

A health care delivery system composed of physicians or providers who have contracted to provide health care services to enrollees of managed care health plans.

Notice of Network Requirements

The document which provides employees with instructions on what to do if an injury occurs. Each certified WC network is required to provide employees with a written notice of network requirements. Additional information may be found at the following website: <http://www.tdi.texas.gov/wc/wcnet/indexwcnet.html>.

Out of Network

A physician, doctor, health care practitioner, health care provider, or hospital or facility that is not under contract with a HMO, PPO or WC Network.

Preauthorization

The process required requesting approval from the insurance carrier to provide a specific treatment or service before the treatment or service is provided.

Preferred Provider Organization (PPO)

Hospital, physician, or other provider of health care which an insurer recommends to an insured. A PPO allows insurance companies to negotiate directly with hospitals and physicians for health services at a lower price than would be normally charged.

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Primary Care Physician (PCP)

A physician who is responsible for providing care to patients, maintaining the continuity of patient care, and initiating referral for care.

Quality Improvement (QI)

A system designed to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions of a network or carrier.

Reconsideration

A request to a carrier or network to reconsider their denial of medical services (adverse determination) from an injured employee or healthcare provider on behalf of an injured employee.

Referrals - In Network

A directive or request from a primary care physician and/or treating doctor that allows the patient to receive care from a specialist or other contracted provider within the geographical service area.

Referrals - Out of Network

A directive or request from a physician or provider for health care services to be provided outside the geographical service area when care is not available within the network.

Retrospective Review

A system in which review of medical necessity and appropriateness of health care services provided to an injured employee is performed for the first time subsequent to the completion of such health care services. Retrospective review does not include subsequent review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted.

Self-Funded/Self-Insured Benefit Plans

A benefit plan arranged and funded by an employer to pay for claims incurred by enrollees or employees.

Service Area

A geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area.

Small Group Employer

A person or entity who employed an average of at least two employees but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the policy year. For purposes of this definition, a partnership is the employer of a partner. A small employer includes an independent school district that elects to participate in the small employer market as provided under Insurance Code Article 26.036.

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Third Party Administrator

A person who is not an original party to the benefit plan who collects premiums, contributions from, or who adjusts or settles claims in connection with life, health, accident and pharmacy benefits or annuities for residents of this state.

Treating Doctor

A physician or provider who is responsible for providing primary care and treatment and for initiating referrals for specialist care for an injured employee's work-related injury or illness. Very similar to a primary care physician under a health care plan.

Unjustified Complaint

A complaint wherein there is no apparent violation of a policy provision, contract provision, rule or statute, or there is no valid concern that a prudent layperson would regard as a practice or service that is below customary business or medical practice.

Utilization Review Agent (URA)

An entity that conducts utilization review of the medical necessity and appropriateness of health care services on a prospective, concurrent, or retrospective basis.*

*Note: Also defined under 28 TAC §19.1703(37), [https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=T&app=9&p_dir=P&p_rloc=160689&p_tloc=&p_ploc=1&pg=2&p_tac=&ti=28&pt=1&ch=19&rl=1703](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=P&p_rloc=160689&p_tloc=&p_ploc=1&pg=2&p_tac=&ti=28&pt=1&ch=19&rl=1703), and defined under 28 TAC §19.2003(34), [http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rl oc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=19&rl=2003](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rl oc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=19&rl=2003)

URA – Certified

A certified entity that conducts utilization review for a health benefit plan or health insurance policy; also a payor or an administrator holding a certificate of authority under Chapter 4201,

<http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.4201.htm#4201.001.00>.

URA – Registered

A licensed insurance company or health maintenance organization that performs utilization review only for its own insureds or enrollees.

Workers' Compensation Non-Network

A type of insurance policy which provides covered employees with medical benefits and income benefits if a covered employee suffers a work-related injury or illness.

- Non-network Workers' Compensation (WC) is regulated by the Division of Workers' Compensation (DWC) of the Texas Department of Insurance.
- Workers' Compensation Networks are regulated by the Managed Care Quality Assurance (MCQA) Office of the Texas Department of Insurance.

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