



## Health Insurance Terms to Know

To begin understanding the complexities of health insurance today, it is first necessary to learn the language. This flyer contains terms used in health insurance that may be helpful in understanding your HealthChoice managed care organization.

**Appeal** – The formal process of disagreement with the decision of a managed care organization (MCO).

**Authorization** – An approval of service from the MCO. These are usually written with an authorization number assigned to the approval. This is different from a referral.

**Auto-assignment** – New HealthChoice enrollees must choose a MCO and primary care provider or they will be chosen for them. Most new enrollees have 21 days to choose. Children who are in foster or kinship care have 60 days.

**Benefit Package** – Services specifically defined as those that can be provided to health plan enrollees.

**Complaint or grievance** – Usually a formal notification to a MCO of a concern or complaint regarding access to care, termination or reduction of benefits, or other problems encountered by an enrollee including concerns about your relationship with a plan provider.

**DME** – Durable medical equipment such as wheelchairs and feeding pumps.

**DMS** – Disposable medical supplies such as special diapers or Attends and disposable feeding bags.

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** – Federally mandated benefits for Medicaid (HealthChoice) recipients under age 21 whether or not they are enrolled in a managed care program.

**Explanation of Benefits (EOB)** – A written statement mailed to you by your insurance company that explains the payment made to providers, the amount you are responsible for paying, and any denials of coverage, including the reason for the denial. Usually, denials on EOBs are related to a duplicate charge or inaccurate provider coding. If the EOB contains a denial of coverage based on the medical necessity of the service, you should receive a separate letter with a full explanation of why the procedure, treatment, or therapy was denied. If you receive a denial and do not receive a separate letter with a full explanation and information on how to file an appeal, you should request such a letter as soon as possible.

**Formulary** – A list of prescription drugs approved for use by the health plan

**Gatekeeper** – Usually the Primary Care Provider who directly provides primary care, coordinates all diagnostic tests and referrals for specialty services. Inpatient admissions, referrals, and some procedures must often be pre-authorized by the Gatekeeper, except in an emergency.

In-network – Managed care organizations contract with select primary care providers, specialty providers, hospitals, DME/DMS providers, dentists, and pharmacies to deliver services to their members. Typically, a member of a MCO must use these providers when accessing any care or service.

Medically Necessary Services – Criteria the MCO uses to determine if care or services are appropriate and necessary for the symptoms, diagnosis, or treatment of a medical condition.

Pre-Admission Certification and/or Review – Approval by a MCO for a person to be admitted to a hospital or other in-patient facility prior to admission.

PCP – Primary Care Provider – typically a family practitioner, pediatrician, internist, or nurse practitioner who provides health care services and oversees a patient's total care (immunizations, well child care, etc.), including referrals for specialty services, procedures, and hospitalization.

Referral – The PCPs recommendation for a service, usually in written form. Often the MCO enrollee must present the referral before a specialist can render care. This referral may or not be considered an authorization.

Spend-down – A term used in Medical Assistance for persons whose income/assets are above the eligibility threshold, but when medical expenses are factored in may be eligible.

Utilization Review – Evaluation of the medical necessity and appropriateness of a medical service or procedure, inpatient admission and length of stay. Utilization review may be conducted prior to the provision of a service, concurrent with the service, and after the service has been provided. A medical professional should conduct utilization review.

For more information about HealthChoice go to our web site at <http://www.bhca.org> or call our Health Education and Outreach Department at 410-649-0521.



***Your Voice in HealthChoice***