

## **XX. GLOSSARY OF TERMS**

**AFDC** - Aid to Families with Dependent Children under Title IV-A of the Social Security Act, as amended - a mandatory Medicaid population.

**Ancillary and Allied Provider Services** - refers to supplemental health care services such as; pharmacy, home health, dental, vision, medical supplies, durable medical equipment, transportation, laboratory.

**Appeal** - The formal mechanism which allows a member or a Provider the right to question a grievance decision.

**Authorization** - An administrative procedure whereby Missouri Care gives approval of medical services rendered to members, such as outpatient procedures, hospitalization, referrals to a physician specialist, etc.

**Auto Assignment** - An automated method of enrolling MC+ eligible persons with a health plan.

**Billed Charges** - Charges billed by a Provider rendering service to a Missouri Care member.

**Board Certified** - A physician who has successfully completed a required residency in an approved training facility, meets the experience requirements and has passed the examination of the respective board.

**Capitation Payment** - refers to a predetermined periodic payment, based upon the number of assigned members, that is made to Provider by Missouri Care for providing Covered Services for a specific period.

**Clean Claim** - Refers to a claim that may be processed without obtaining additional information from the Provider of service or from a third party.

**Complaint** - A verbal or written expression by a member or Provider which indicates dissatisfaction or dispute with health plan policy, procedure, claims, or any aspect of health plan functions. All complaints will be logged whether received by phone, in person or in writing.

**Concurrent Review** - A type of patient/medical care evaluation study performed while a patient is still hospitalized, that may involve process or intermediate outcome criteria and regular data collection.

**Contract** - Refers to the present and future Agreement between Missouri Care and the State of Missouri for the purpose of providing health care services under the MC+ Program.

**Contractor** - Refers to Missouri Care

**Co-Payment** - Refers to a monetary amount, specified by the State Agency, which the member may be responsible to pay directly to the participating health Provider at the time Covered Services are provided.

**Covered Services** - Refers to those specific services and goods available to members pursuant to the Missouri MC+ program, statute, and rules and regulations, the Provider contract, Missouri Care medical policies and procedures, and the Provider Manual.

**CQI** - Continuous Quality Improvement

**C-STAR** - Comprehensive Substance Abuse and Rehabilitation Programs.

**Discharge Planning** - Identification of the need and provision for a member's health care requirements after discharge from the hospital.

**Disenrollment** - The discontinuance of a member's entitlement to receive Covered Services from a Contractor. The member's name is deleted from the approved list of members furnished by the State to the Contractor.

**DME** - Durable Medical Equipment - includes wheelchairs, oxygen equipment, hospital beds, walkers, etc.

**DMS** - Division of Medical Services. This division located within the Missouri Department of Social Services is officially designated for administration of the State's medical assistance and federal Medicaid programs.

**Elective** - Usually refers to medical procedures, particularly surgery, not immediately necessary to maintain life or health – procedures, which can often be scheduled weeks or months in advance.

**Emergency Dental Services** - Those services and operational procedures required to eliminate acute infection, prevent pulpal death and related imminent tooth loss, treat injuries to teeth or supportive structures, or provide palliative therapy for pericoronitis associated with impacted teeth.

**Emergency Medical Services** - Refers to those health care services and/or goods provided or required to evaluate and treat an unexpected onset of a medical or mental health condition that manifests itself by acute symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of health and medicine, to believe

that immediate medical care is required for such condition which may include, but shall not be limited to:

- A. Placing the member's physical or mental health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- B. serious impairment to a bodily function; or
- C. serious dysfunction of any body organ or part; or
- D. serious harm to a member or others due to an alcohol or drug abuse emergency; or
- E. injury to member or bodily harm to others; or
- F. with respect to a pregnant member who is having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the member or the unborn.

**Encounter** - A record of medical services provided to a member.

**Enrollment** - The process by which a person who has been determined eligible becomes a member in a contractor's plan under the Missouri MC+ program. During the enrollment process, the person often has more than one plan from which to choose.

**EPSDT Services** - Providers are required to participate in the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Program (see also "HCY") for all assigned members under the age of twenty-one (21) years in accordance with the EPSDT Periodicity schedule. Please refer to your EPSDT Provider Manual for more details.

**Fee-For-Service Payment (FFS)** - Refers to a payment to a Provider by Missouri Care for certain Covered Services that is the lower of the Provider billed and usual charge or Missouri Care's fee schedule.

**FQHC/RHC** - Federally Qualified Health Centers/Rural Health Centers

**Grievance** - A written request for further review of a member's or a Provider's complaint that remains unresolved after completion of the complaint process.

**HCY** - Healthy Children and Youth Program which provides EPSDT services to individuals under the age of twenty-one (21).

**HIPPA** – The Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), as codified at 42 U.S.C. §§ 1320d through 1320d-8 and as further delineated in regulations within Parts 142, 160 and 164 of 45 C.F.R. The Administrative Simplification provisions under HIPAA impose standards for the electronic exchange and protection of private health information to make financial and administrative healthcare transactions more efficient and secure. "HIPAA Privacy Standards" means the portion of HIPAA that covers standards for the privacy of individually identifiable health information. "HIPAA Transaction Standards" means the portion of HIPAA that covers standards for electronic transactions and code sets. "HIPAA Identifier Standards" means the portion of HIPAA that covers national standard identifiers for health care providers, health plans, employers and individuals (if any). "HIPAA

Security Standards” means the portion of HIPAA that covers security and electronic signature standards.

**Home Health Care** (Home Health Services) - Medical care services provided in the home, often by a visiting nurse, usually for patients with chronic disease or disability, recovering patients, or aged homebound patients.

**Hospital** - A health care institution which is:

- a. Licensed by the State of Missouri as a hospital, and
- b. certified as a provider under Title XVIII of the Social Security Act, as
- c. amended, or is currently determined to meet the requirements of such certification.

**Inpatient** - A patient admitted to an overnight medical facility such as a hospital.

**Inquiry** - A request from a member or Provider for information that would clarify health plan policy benefits, procedures, or any aspect of health plan function that may be in question. Inquiries will be investigated to validate the possibility of an inquiry actually being a complaint.

**Length Of Stay** - The number of days a patient is an inpatient, per episode. The length of time a patient is hospitalized. Total number of days for which a patient is hospitalized, either totally or in a particular unit or level of care; abbreviated as LOS.

**Local Health Agencies** - Administer public health programs that provide “core services” such as immunizations, family planning, and screening, diagnosis, and treatment for sexually transmitted disease, HIV, tuberculosis, and lead poisoning. These services will be reimbursed by Missouri Care.

**MC+ for Adults** – Health care coverage that has been extended to low-income parents who do not have access to health insurance.

**MC+ for Kids** – Missouri’s health insurance program for uninsured children. Part of the federal Children’s Health Insurance Program, is a health insurance program for low-income families who do not have access to affordable health insurance.

**MC+ Program (MC+)** - Missouri Medicaid managed care program.

**Medicaid** - A federal/state program under Title XIX of the Social Security Act providing federal matching grants, at State's option, for a medical assistance program for recipients of federally aided public assistance and SSI benefits and the medically indigent. Certain minimal programs and services must be included to receive federal matching funds, however, states may optionally include any additional services at state expense.

**Medical Director** - Refers to a Missouri-licensed physician who is designated by Missouri

Care to have overall administrative responsibility for the direction of Missouri Care's medical delivery system.

**Medically Necessary** - Refers to those Covered Services provided or furnished, which:

- A. are reasonably and clinically required for the diagnosis or treatment of illness or injury to improve the function of a malformed body member or to minimize the progression of disability; and
- B. could not have been omitted without adversely affecting the member's
- C. condition or the quality of medical care rendered; and
- D. are furnished in accordance with accepted standards of practice in the medical community of the area in which health services are rendered; and
- E. are furnished in the most appropriate setting

**Medically Necessary behavioral health services** - refers to those Covered Services:

- A. which have been determined to be appropriate by process of behavioral health assessment that determines the clinical condition of the member and;
- B. meet acceptable standards of practice for such clinical conditions among the community of qualified mental health and substance abuse Providers of the area in which services are provided.

**Medically Necessary Dentures** - Partial or full dentures and services that are determined to be the primary treatment of choice or an essential part of an overall treatment plan designed to alleviate a medical condition as determined by the Primary Care Provider in consultation with a dentist.

**Medicare** - A federal program under Title XVIII of the Social Security Act which provides health insurance for persons age sixty-five (65) and older and for other specified groups. Part A of Medicare covers hospitalization and is compulsory and Part B of the program covers outpatient services and is voluntary.

**Member** - Refers to an individual who has been determined MC+ eligible and enrolled with Missouri Care to receive services.

**NCQA** - National Committee for Quality Assurance - an independent external review association for health care quality management-

**NPI** - National Provider Indicator – a standard, unique identifier for all health care providers.

**Occupational Therapy** - Medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning.

**Out-Of-Area-Care** - Care received by a Missouri Care enrollee when they are outside of their geographic territory.

**Outpatient** - A member who goes to a licensed health care institution or a facility for care and services, but who does not occupy an inpatient bed.

**Participating Health Professionals** - Refers to those Primary Care Providers, Provider specialists, medical facilities, allied health professionals and ancillary service Providers, under contract with Missouri Care to provide specific Covered Services to members, and represent those individuals and entities to be utilized through the Missouri Care Prior Authorization and Referral Policies and Procedures.

**PCO** - Primary Care Obstetrician - a physician, nurse practitioner, or certified nurse midwife, licensed to practice in the field of obstetrics/gynecology, who provides obstetrical and primary care to assigned pregnant members during the course of the pregnancy and sixty (60) days postpartum.

**PCP** - Primary Care Provider - is a Provider who serves as the gatekeeper to supervise, coordinate and provide initial, primary and preventive care to members, initiate referrals for specialty care, follow specialty care and maintain continuity of care. May be a: a) licensed resident specializing in family and general practice, pediatrics, or internal medicine; b) registered nurse who is an advanced practice nurse specializing in family and general practice, pediatrics, or internal medicine; or c) licensed physician in the following specialty: family and general practice, pediatrics, or internal medicine.

**Pharmaceutical Services** - Medically Necessary drugs prescribed by a Primary Care Provider or other Provider or dentist upon referral by a Primary Care Provider and dispensed in accordance with Missouri Law.

**Physician Services** - Services provided within the scope of practice of medicine or osteopathy as defined by State law or under the personal supervision of an individual licensed under State law to practice allopathic medicine or osteopathy.

**Preventive Health Care** - Those health care activities aimed at protection against, and early detection and minimization of, disease or disability.

**Prior Authorization** - a unit under the direction of the Medical/Quality Management Department, which is an essential component of any managed care organization. Prior Authorization is the process where health care Providers seek approval prior to rendering specific services as required by Missouri Care policy.

**Provider** - generally used to identify physicians, hospitals, etc., who provide medical services to Missouri Care members.

**Provider Manual** - the collection of policies and procedures, as revised from time to time, that may be established and communicate to PHP by Missouri Care including without limitation credentialing, prior authorization, utilization review, quality management

programs and administrative and grievance procedures. Missouri Care may revise the Provider Manual by issuing updates, provider newsletters, or bulletins.

**Provider Network** – all of Missouri Care’s Participating Health Providers.

**PSP** - Participating specialist physician

**Quality Management (QM)** - A methodology used by professional health personnel that reviews the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

**Records** - refers to a medical record and other reports, documents or statements relating to the delivery of services under the MC+ program, e.g., financial statements, prescription files, statistical reports.

**Retrospective Review** – To look over after the fact. Used often with respect to utilization management - as with retrospective review and approval or denial of emergency room use.

**SAFE-CARE** - Sexual Assault Forensic Examination (SAFE) and Child Abuse Resource Education (CARE) exams. These exams are reimbursed by the State on a fee-for-service basis to Providers certified by the Missouri Department of Health to perform the exams.

**Short Stay/Observation Unit** - A clinical unit which provides Medically Necessary Covered Services to a member whose condition does not meet acute care criteria nor warrant an inpatient stay, yet, observation or other outpatient services are required.

**SOBRA** - refers to a special membership classification of pregnant women, mothers and babies, who are members of Missouri Care.

**Specialist** - A physician duly licensed in the State of Missouri and has completed a residency or fellowship in his/her specialty and has been approved to sit for the board examination for the specialty.

**SSI** - Supplemental Security Income under Title XVI of the Social Security Act, as amended.

**TANF** - Temporary Assistance for Needy Families (Transitional Medical Assistance.)

**Third Party Recoveries** - A general term applied to healthcare benefit payments. It derives from the fact that under normal market transactions, there are only two (2) parties, the consumer and the supplier, but under a benefit plan, a third party (e.g., government, an insurance company, an employer etc.) is ultimately responsible to pay the costs of services provided to covered person.

**Title XIX** - Section of Social Security Act which describes the Medicaid program's

coverage for eligible persons

**Uninsured** – To be considered uninsured, a child must have been without access to health care insurance for six (6) months prior to application to Medicaid. Adults may apply if they had not had health insurance for six (6) months. If they dropped health insurance, they must wait for six (6) months after dropping the insurance to apply for the MC+ program unless they lost a job but did not quit the job; got a new job that does not have insurance; or COBRA insurance ends.

**Utilization Management** (Utilization Review, Utilization Control) - Systematic means for reviewing and controlling members' use of medical care services, and Providers' use of medical care resources. Usually involves data collection, review and/or authorization, especially for services such as specialist referrals and emergency room use and particularly costly services such as hospitalization.

**Utilization Review** - System of review conducted by professional health personnel, of the appropriateness, quality of and need for health care services rendered to patients covered by Medicare or other third party payors, including MC+.

**WIC** - Women, Infants and Children Supplemental Food Program.