



**Molina Healthcare of California
Provider/Practitioner Manual**

Glossary/Index

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Section 2: Glossary of Terms

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SECTION 2: GLOSSARY OF TERMS

Aid to Families with Dependent Children (AFDC) - A program offered by the State of California that provides cash grants, food coupons, and medical benefits for low income families.

Appeal - An appeal is a request for reconsideration of a determination for authorization of a service or the denial of a claim.

Authorization - Approval requested and obtained by Providers/Practitioners for designated service before the service is rendered. Used interchangeably with preauthorization or prior authorization.

Beneficiary Identification Card (BIC) - A permanent plastic card issued by the State to recipients of entitlement programs which can be used by contractors to verify health plan eligibility. Files are updated monthly, as well as daily in special circumstances.

California Children Services (CCS) - A State and County program providing medically necessary specialized medical care and rehabilitation to persons under 21 years of age (as defined in Title 22, CCR, Section 41800) who meet medical, financial, and residential eligibility requirements for the CCS program.

Child Health and Disability Prevention Program (CHDP) - Preventive well-child screening program for eligible beneficiaries under 21 years of age provided in accordance with the provisions of Title 17, CCR, Section 6800 et seq. Includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, and the Prenatal Guidance Program.

Central Issuance Division (CID) - A unit at DHS that reports for eligibility data systems.

Claim - A request for payment for the provision of Covered Services prepared on a HCFA 1500 form, UB-92, or successor.

Comprehensive Perinatal Services Program (CPSP) - A State sponsored program developed to provide quality health care for women during and surrounding pregnancy by encouraging evaluation in obstetrical, nutritional, social, and educational spheres to assess and address high-risk conditions.

Contracting Provider - A physician, nurse, technician, hospital, home health agency, nursing home, or any other individual or institution contracted to provide medical services to health plan members.

Credentialing - The verification of applicable licenses, certifications, and experience to assure that Provider/Practitioner status be extended only to professional, competent Providers/Practitioners who continuously meet the qualifications, standards, and requirements established by Molina Healthcare.

Department of Managed Health Care (DMHC) - The State department responsible for administering the Knox-Keene Act of 1975. Knox-Keene established the DMHC as the legally designated State regulatory agency for managed health care organizations.

Department of Health Services (DHS) - The State department solely responsible for administration of the Medi-Cal, CPSP, CCS, CHDP, and other health related programs.

Department of Mental Health (DMH) - The State agency that sets policy and administers the delivery of community-based public mental health services statewide.

Direct PCP - A Primary Care Practitioner (PCP) that holds a contract with Molina Healthcare.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program - The initial, periodic, or additional health assessment of a Medi-Cal eligible individual under 21 years of age provided in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program as set forth in Title 17, CCR, Sections 6800 et seq. The program consists of periodic and episodic screening services, diagnostic and treatment services, and supplemental services, including case management services.

Eligible Beneficiary - Any Medi-Cal beneficiary who resides in the contractor's service area and who falls into one or more of the following categories (with a specific aid code): Aid to Families with Dependent Children, Medically Needy Family, Public Assistance Aged, Medically Needy Aged, Public Assistance Blind, Medically Needy Blind, Public Assistance Disabled, Medically Needy Disabled, Medically Indigent Child, Medically Indigent Adult, and Refugees.

Emergency Care - The provision of medically necessary services required for the immediate alleviation of severe pain or the immediate diagnosis and treatment of an unforeseen illness or injury. Lack of such care could lead to disability or permanent damage to the patient's health if not diagnosed and treated without delay.

Encounter Data - Reports submitted by Providers/Practitioners, IPA/Medical Groups, and affiliated subcontracted health plans documenting encounters with plan members. Encounter data may also be drawn from Molina Healthcare or its affiliated subcontracted health plan via aggregate claims data from the Management Information System.

Enrollment Form - See "Medi-Cal Choice Form."

Evidence of Coverage (EOC) - The document provided to plan members describing access, benefits, and exclusions of plan services.

Fee-For-Service (FFS) - A method of charging based upon billing for a specific number of units of services rendered to an Eligible Beneficiary. Fee-For-Service is the traditional method of reimbursement used by Providers/Practitioners, and payment almost always occurs retrospectively.

Geographic Managed Care (GMC) - A program which requires Medi-Cal beneficiaries who reside in a designated geographic area to enroll in one of two or more competing health plans under contract with the DHS.

Health Care Options (HCO) (formerly Health Choice) - The State Department of Health Services' program that provides Medi-Cal beneficiaries with information about healthcare benefits and with enrollment and disenrollment assistance.

Health Maintenance Organization (HMO) - An organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined, periodic, and fixed prepayment.

Independent Practice Association (IPA) - A legal entity, the members of which are independent Providers/Practitioners who contract with the IPA for the sole purpose of having the IPA contract with one or more HMOs.

Indian Health Service (IHS) Facilities - Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act and through which services are provided, directly or by contract, to an eligible Indian population within a defined geographic area.

Management Information System (MIS) - System of organizing and aggregating data so as to enable rapid access to data. Often used to refer to computer systems used to pay claims, maintain Provider/Practitioner databases, and generate reports.

Maximus - The vendor contracted by the Department of Health Services that provides Medi-Cal beneficiaries with information about selecting a health plan. Maximus is also responsible for the mailing of enrollment packets to new Medi-Cal beneficiaries.

Medi-Cal Choice Form - A.K.A. Medi-Cal Enrollment Form. This form is distributed by Health Care Options (HCO) and is used for Medi-Cal Beneficiaries to select their health plan and primary care practitioner. This form may also be used for beneficiaries to disenroll from a health plan.

Medical Group - A medical group practice that holds a contract with a health plan.

Medical Records - A confidential document containing written documentation related to the provision of physical, social, and mental health services to a member.

Medically Necessary - The level of medical or surgical treatment and supplies and/or behavioral health care requisite for the diagnosis and treatment of disease, illness, or injury.

Medical Eligibility Data System (MEDS) Tape - The computerized data vehicle (tape) DHS sends monthly to Molina Healthcare for member eligibility determination. This tape must be processed by Molina Healthcare to extract the data regarding eligibility prior to printing updated eligibility rosters and calculating capitation payments.

Member - Any enrolled individual on whose behalf periodic payments are made to Molina Healthcare by the State of California.

Member Complaint/Grievance - A grievance is any expression of dissatisfaction or complaint by a member or member's designated representative that remains unresolved to the member's satisfaction.

NCQA - The National Committee for Quality Assurance.

Newborn Child - A newborn child is covered for the month of birth and the following month when delivered by the mother during her membership with the Plan.

Plan - Molina Healthcare of California.

Potential Quality of Care (PQOC) - Process to identify opportunities to evaluate, review, and address a potential quality of care issue.

Practitioner - The professional who provides health care services. Practitioners are required to be licensed as defined by law. A practitioner that participates in Molina Healthcare's network may be referred to as a "participating or contracted" practitioner.

Preventive Care - Health care designed to prevent disease and/or its consequences. There are three (3) levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after disease has occurred.

Primary Care - A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and/or mid-level practitioners. This type of care emphasizes caring for the member's general health needs as opposed to focusing on specific needs involving the use of specialists.

Primary Care Practitioner (PCP) - Physician that provides primary care services (including family practice, general practice, internal medicine, and pediatrics) and manages routine health care needs. A woman may select an obstetrician/gynecologist as her PCP.

Provider - An institution or organization that provides services for the managed care organization's members. Examples of providers include hospitals and home health agencies. NCQA uses the term "practitioner" to refer to the professionals who provide health care services. However NCQA recognizes that a "provider directory" generally includes both providers and practitioners, and the inclusive definition is the more common usage of the term "provider." A provider that participates in Molina Healthcare's network may be referred to as a "participating or contracted" provider.

Provider/Practitioner Grievance or Complaint - That written action which sets into motion the appeal process concerning claims or authorization disputes according to Title 22, sections 53914.5 and 56262 of the California Code of Regulations.

Quality Improvement (QI) - A formal set of activities to assure the quality of clinical and non-clinical services provided as outlined in Molina Healthcare's Quality Improvement Program. Quality Improvement includes assessment and improvement actions taken to remedy any deficiencies identified through the assessment process. The Providers/Practitioners agree to abide by and participate in Molina Healthcare's QI Program.

Referral - The practice of sending a patient to another Provider/Practitioner for services or consultation which the referring Provider/Practitioner is not prepared or qualified to provide.

Sensitive Services - The following services are considered sensitive: sexual assault, confidential HIV testing and counseling, drug or alcohol abuse for children of 12 years of age or older, pregnancy, family-planning, and sexually transmitted diseases (drug or alcohol abuse and sexually transmitted diseases are designated by the Director of DHS for children 12 years of age or older).

Service Area - The geographic area that the Plan services as designated and approved by the California Department of Managed Health Care.

Short-Doyle Medi-Cal Mental Health Services (SD/MC) - Program operated by the State Department of Mental Health to provide necessary community mental health services to Medi-Cal beneficiaries that meet Short-Doyle eligibility criteria as defined in Title 22, CCR, Section 51341. Services include crisis intervention, crisis stabilization, inpatient hospital services, crisis residential treatment case management, adult residential treatment, day treatment intensive, rehabilitation, outpatient therapy, medication, and support services.

Specialist - A physician who is responsible for the specific, specialized health care of a member. A specialist may or may not be board certified.

Utilization Management (UM) - A formal prospective, concurrent, and/or retrospective critical examination of appropriate use of segments of the health care system.

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