Definition of Terms

**Abuse** – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

**Action** – The denial or limited Authorization of a requested service, including the type, level or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

**Adverse Action** – A determination made in response to Grievances, Complaints or Appeals wherein Molina Healthcare’s original proposed Action is upheld.

**Ancillary Services** – Health care services ordered by a provider, including but not limited to: laboratory services, radiology services, and physical therapy.

**Appeal** – A written request by a Member or Member’s Authorized Representative received at Molina Healthcare for review of an Action.

**Authorization** – Approval obtained by providers from Molina Healthcare for a designated service before the service is rendered. The term is used interchangeably with preauthorization or prior Authorization.

**Authorized Representative** – For purposes of filing a Complaint, Grievance, or Appeal, an individual appointed by the Member, including a provider or estate representative.

**Centers for Medicare and Medicaid Services (CMS)** – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

**Claim** – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.

**Complaint** – A general term used to describe a Member’s oral expression of dissatisfaction with Molina Healthcare. It can include access problems, such as difficulty getting an appointment or receiving appropriate care; quality of care issues, such as long wait times in the reception area of a provider’s office, rude providers or provider staff; or denial or reduction of a service. A Complaint may become a Grievance or Appeal if it is subsequently submitted in writing.

**Coordination of Benefits (COB)** – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

**Covered Services** – Medically Necessary services included in the State contract. Covered Services change periodically as mandated by Federal or State legislation.
Credentialing – The verification of applicable licenses, certifications, and experience to assure that provider status be extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by Molina Healthcare.


Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, providers’ offices and home health care.

Department of Health Services (DHS) — The Wisconsin Department of Health Services, the department responsible for overseeing State-funded insurance programs.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than for convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a provider.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid as defined in the Social Security Act section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any Medically Necessary services found during the EPSDT exam.

Emergency Care – The provision of Medically Necessary services required for the immediate attention to evaluate or stabilize a Medical Emergency (See definition below).

Encounter Data – Molina Healthcare shall collect, and submit to DHS, enrollee service level Encounter Data for all Covered Services.

Excluded Providers – An individual provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been: convicted of crimes as specified in section 1128 of the Social Security Act, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Expedited Appeal – An oral or written request by a Member or Member’s Authorized Representative received by Molina Healthcare requesting an expedited reconsideration of an Action when taking the time for a standard resolution could seriously jeopardize the Member’s life, health or ability to attain, maintain, or regain maximum function; or would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Appeal.

Expedited Grievance – A Grievance where delay in resolution would jeopardize the Member’s life or materially jeopardize the Member’s health.
**Fee-For-Service (FFS)** – A term Molina Healthcare uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a Member.

**Fraud** – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable Federal or State law. (42 CFR § 455.2)

**Grievance** – An expression by a Member or Authorized Representative of dissatisfaction or a Complaint about any matter other than an Action. The term is also used to refer to the overlap system of Complaints, Grievances and Appeals handled by Molina Healthcare. Possible Grievance subjects include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member’s rights.

**Healthcare Effectiveness Data and Information Set (HEDIS)** – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers’ needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.


**Independent Practice Association (IPA)** – A legal entity, the members of which are independent providers who contract with the IPA for the purpose of having the IPA contract with one (1) or more health plans.

**Medicaid** – The State and federally funded medical program created under Title XIX of the Social Security Act.

**Medical Emergency** – Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the Member’s life or health would have been jeopardized had the care been delayed.

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

**Medically Necessary** or **Medical Necessity** – Services that include medical or allied care, goods or services furnished or ordered that are:

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient’s needs;
- Consistent with the generally accepted professional medical standards as determined by applicable Federal and State regulation or law, and not be experimental or investigational;
Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and

Furnished in a manner not primarily intended for the convenience of the Member, the Member’s caretaker, or the provider.

**Medicare** – The Federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two (2) parts:

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare provider’s services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

**Member** – A current member of Molina Healthcare.

**NCQA** – National Committee for Quality Assurance

**Participating Provider** – A provider that has a written agreement with Molina Healthcare to provide services to Members under the terms of his/her agreement.

**Preventive Care** – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

**Primary Care Provider (PCP)** – A Participating Provider responsible for supervising, coordinating, and providing primary health care to Members, initiating Referrals for Specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to; pediatricians, family practice providers, general medicine providers, internists, obstetrician/gynecologists, physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNP), as designated by Molina Healthcare.

**Provider Group** – A partnership, association, corporation, or other group of providers.

**Quality Improvement Program (QIP)** – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

**Referral** – The practice of sending a patient to another provider for services or consultation which the referring provider is not prepared or qualified to provide.

**Remittance Advice (RA)** – Written explanation of processed Claims.

**Service Area** – A geographic area serviced by Molina Healthcare, designated and approved by DHS.

**Specialist** – Any licensed provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.
**State Children's Health Insurance Plan (SCHIP)** – A Federal/State funded health insurance program authorized by Title XXI of the Social Security Act and administered by DHS.

**Sub-Contract** – A written agreement between Molina Healthcare and a Participating Provider, or between a Participating Provider and another sub-contractor, to perform all or a portion of the duties and obligations Molina Healthcare is required to perform pursuant to the agreement.

**Supplemental Security Income (SSI)** – A Federal cash program for aged, blind, or disabled persons, administered by the SSA.

**Title XIX** – The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

**Title XXI** – The portion of the Federal Social Security Act that authorizes grants to states for SCHIP.

**Utilization Management (UM)** – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, Discharge Planning and case management.

**Waste** – Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent. However, the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.