# GLOSSARY OF TERMS

**Abuse-** provider practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost 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 program (42 CFR 455.2 and as further defined in Elf. & Inst. Code 140343.a(a)

**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 wellchild 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 DHCS that reports for eligibility data systems.

**Claim** A request for payment for the provision of Covered Services prepared on a CMS 1500 form, UB04, PM160 for CFDP Services or successor.

**Clean Claims** A claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

**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 highrisk 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.

**Conviction** (or convicted)- A judgment of conviction has been entered by a Federal, State or local court regardless of whether an appeal from that judgment is pending (42CFR 455.2). This definition also includes the definition of the term "convicted" in Welfare and instructions Code Section 14043.1(f)

**Covered Services** Those healthcare services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Plan product which covers the Member.

**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 KnoxKeene Act of 1975. KnoxKeene established the DMHC as the legally designated State regulatory agency for managed health care organizations.

**Department of Health Care Services (DHCS)** The State department solely responsible for administration of the MediCal, CPSP, CCS, CHDP, and other health related programs.

**Department of Mental Health (DMH)** The State agency that sets policy and administers the delivery of communitybased 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 MediCal 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 MediCal 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 Services** Covered Services necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (a) placement of the Member's health (or the health of the Member's unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114.

**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 "MediCal Choice Form."

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

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

**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 (42CFR455.0; Welf & Inst Code 14043.1(i)

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

**Healthcare Effectiveness Data and Information Set (HEDIS) –** A widely used set of performance measures in the managed care industry developed and maintained by the National Committee for Quality Assurance (NCQA). 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 card for managed care organizations.

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

**Health Insurance Portability and Accountability Act (HIPAA) –** The Federal Law that requires all healthcare providers to protect the privacy and security of members protected health information (PHI).

**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 SelfDetermination 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 Care Services that provides MediCal beneficiaries with information about selecting a health plan. Maximus is also responsible for the mailing of enrollment packets to new MediCal beneficiaries.

**MediCal Choice Form** A.K.A. MediCal Enrollment Form. This form is distributed by Health Care Options (HCO) and is used for MediCal 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** Those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Plan policy.

**Medical Eligibility Data System (MEDS) Tape** The computerized data vehicle (tape) DHCS 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 and is eligible to receive covered services.

**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.

**National Provider Identifier (NPI)** – The National Provider Identifier is a 10 digit number assigned by Centers for Medicare & Medicaid Services (CMS) to all covered providers of healthcare who transmit information electronically (HIPAA Transactions). The NPI is intended to improve efficiency and effectiveness of the healthcare system by reducing the number of identifiers associated with providers and facilities (i.e. UPIN, BCBS, Medicaid, other payer specific numbers). As of May 23, 2007 any healthcare provider who transmits heath information electronically is required to have an NPI. All HIPAA transactions must use an NPI as the sole means to identify a provider of service. The NPI number last indefinitely and does not change regardless of job or location changes. There are 2 types of NPI: Individual: Physicians, physician assistants, nurse practitioners, chiropractors. Organization: Hospitals, clinics, labs (May have multiple NPIs for each subpart – urgent care, lab, pharmacy, etc.)

**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 Partner Plan, Inc.

**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 midlevel 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.

**Protected Health Information (PHI) –** Under the US Health Insurance Portability and Accountability Act (HIPPA), is any information about health status, provision of health care, or payment for health care that can be linked to an individual; including any part of a patient's medical record or payment history.

**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 nonclinical 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, familyplanning, and sexually transmitted diseases (drug or alcohol abuse and sexually transmitted diseases are designated by the Director of DHCS 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.

**ShortDoyle MediCal Mental Health Services (SD/MC)** Program operated by the State Department of Mental Health to provide necessary community mental health services to MediCal beneficiaries that meet ShortDoyle 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.

**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
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/Medicare Programs