Definitions and Acronyms

1. Definitions

ACA Expansion Members means individuals less than 65 years of age with income below 138% of the federal poverty level and former foster children up to the age of twenty-six (26) and who were not previously eligible under Title XIX of the Social Security Act prior to the passage of the Affordable Care Act.

Action means, as defined in 42 CFR 438.400(b), the

A. denial or limited authorization of a requested service, including the type or level of service;

B. reduction, suspension, or termination of a service previously authorized by the Department, its agent or Contractor;

C. denial, in whole or in part, of payment for a service which results in the service not being provided;

D. failure to provide services in a timely manner, as defined by Department;

E. failure of an MCO or Prepaid Health Insurance Plan (PHIP) to act within the timeframes required by 42 CFR 438.408(b); or

F. for a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside a Contractor's Network.

Affordable Care Act means the Patient Protection and Affordable Act (PPACA), P.L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.

Appeal means a request for review of an Action, or a decision by the Contractor related to Covered Services or services provided.

Behavioral Health Services means clinical, rehabilitative, and support services in inpatient and outpatient settings to treat a mental illness, emotional disability, or substance abuse disorder.

Cabinet means the Cabinet for Health and Family Services.

Care Coordination means the integration of all processes in response to a Member's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services.

Care Management System includes a comprehensive assessment and care plan care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to a member.

Care Plan means written documentation of decisions made in advance of care provided, based on a Comprehensive Assessment of a Member's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Member and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.

C.F.R. means the Code of Federal Regulations.

Children with Special Health Care Needs means Members who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.

CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that a State is able to continue its existing program and expands insurance coverage to additional low-income, uninsured children.

Claim means any 1) bill for services, 2) line item of service, or 3) all services for a Member within a bill.

CMS means the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, formerly the Health Care Financing Administration.

Commonwealth means the Commonwealth of Kentucky.

Commission for Children with Special Health Care Needs is a Title V agency which provides specialty medical services for children with specific diagnoses and health care services needs that make them eligible to participate in Commission sponsored programs, including provision of Medical care.

Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.

Denial means the termination, suspension or reduction in the amount, scope or duration of a Covered Service or the refusal or failure to provide a Covered Service.

Department means the Department for Medicaid Services (DMS) within the Cabinet, or its designee.

Department for Aging and Independent Living (DAIL) is the Department within the Cabinet which oversees the administration of statewide programs and services on behalf of Kentucky's elders and individuals with disabilities.

Department for Community Based Services (DCBS) is the Department within the Cabinet that oversees the eligibility determinations for the DMS and the management of the foster care program. DCBS has offices in every county of the Commonwealth.

Disenrollment means an action taken by the Department to remove a Member's name from the HIPAA 834 following the Department's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment.

Dual Eligible Member means a Member who is simultaneously eligible for Medicaid and Medicare benefits.

Encounter means a service or item provided to a patient through the healthcare system that include but are not limited to:

A. Office visits;

B. Surgical procedure;

C. Radiology, including professional and/or technical components;

D. Prescribed drugs including mental/behavioral drugs;

E. DME;

F. Transportation;

G. Institutional stays;

H. EPSDT screening; or

I. A service or item not directly provided by the Plan, but for which the Plan is financially responsible. An example would include an emergency service provided by an out-of-network provider or facility.

Encounter Record means the electronically formatted list of Encounter data elements per Encounter as established by the Department.

Enrollment means an action taken by the Department to add a Member's name to the HIPAA 834 following approval by the Department of an eligible Member to be enrolled.

EPSDT means Early and Periodic Screening, Diagnosis and Treatment Program.

EPSDT Special Services means any necessary health care, diagnostic services, treatment, and other measure described in section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses, and conditions identified by EPSDT screening services, whether or not such services are covered under the State Medicaid Plan.

EQRO means the external quality review organization, and its affiliates, with which the Commonwealth may contract as established under 42 CFR 438, Subpart E.

Erred Encounter Record means an encounter record that has failed an edit when a correction is expected by the Department.

Family Planning Services means counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy.

Federally Qualified Health Center (FQHC) means a facility that meets the requirements of Social Security Act at 1905(l)(2).

Foster Care means the DCBS program which provides temporary care for children placed in the custody of the Commonwealth who are waiting for permanent homes.

Grievance means the definition established in 42 CFR 438.400.

Grievance System means a comprehensive system that includes a grievance process, an appeal process, and access to the Commonwealth's fair hearing system.

Health Care Effectiveness Data and Information Set (HEDIS) means a tool used to measure performance on important dimensions of care of services.

HHS means the United States Department for Health and Human Services.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, and the implementing regulations (45 C.F. R. sections 142, 160, 162, and 164), all as may be amended.

HMO means a Health Maintenance Organization licensed in the Commonwealth pursuant to KRS 304.38, et seq.

Homeless Person means one who lacks a fixed, regular or nighttime residence; is at risk of becoming homeless in a rural or urban area because the residence is not safe, decent, sanitary or secure; has a primary nighttime residence at a publicly or privately operated shelter designed to provide temporary living accommodations; has a primary nighttime residence at a public or private place not designed as regular sleeping accommodations; or is a person who does not have access to normal accommodations due to violence or the threat of violence from a cohabitant.

Health Risk Assessment (HRA) means a screening tool used to collect information on a member's health status that includes, but is not limited to member demographics, personal and family medical history, and lifestyle. The assessment will be used to determine member's needs for care management, disease management, behavioral health services and/or other health or community services.

Individuals with Disabilities Education Act (IDEA) is a law ensuring services to children with disabilities. IDEA governs how states and public agencies provide early intervention, special education and related services to eligible infants, toddlers, children and youth with disabilities.

Individual Education Plan (IEP) means medically necessary services for an eligible child coordinated between the schools and the Contractor that complement school services and promote the highest level of function for the child and is coordinated between the schools and the Contractor.

Individuals with Special Healthcare Needs (ISHCN) are Members who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISHCN may have an increased need

for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these Members so the MCO can facilitate access to appropriate services.

Kentucky Department of Insurance (DOI) regulates the Commonwealth's insurance market, licenses insurance agents and other insurance professionals and monitors the financial condition of insurance companies, educates consumers to make wise choices and ensures that Kentuckians are treated fairly in the marketplace.

Kentucky Health Information Exchange (KHIE) means the secure electronic information infrastructure created by the Commonwealth for sharing health information among health care providers and organizations and offers health care providers the functionality to support meaningful use and a high level of patient-centered care.

Managed Care Organization (MCO) means a health maintenance organization (HMO) or insurer which has a contract with the DMS services to provide services to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid Members within the area served by the entity.

Managed Behavioral Healthcare Organization (MBHO) means a behavioral health maintenance organization that provides behavioral healthcare services to members through an organized delivery system across a continuum of care.

Medical Record means a single complete record that documents all of the treatment plans developed for, and medical services received by, the Member including inpatient, outpatient, referral services and Emergency Care whether provided by Contractor's Network or Out of Network Providers.

Medically Necessary or Medical Necessity means Covered Services which are medically necessary as defined under 907 KAR 3:130, and provided in accordance with 42 CFR § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

Member means a Member who is an enrollee as defined in 42 CFR 438.10(a).

MIS means Management Information System.

National Correct Coding Initiative (NCCI) means CMS developed coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits.

NPI means the national provider identifier, required under HIPAA.

Office of Inspector General (OIG) is Kentucky's regulatory agency for licensing all health care, day care and long-term care facilities and child adoption/child-placing agencies in the Commonwealth. The OIG is responsible for the prevention, detection and investigation of fraud, abuse, waste, mismanagement and misconduct by the Cabinet's clients, employees, medical providers, vendors, contractors and subcontractors and it conducts special investigations into matters related to the Cabinet or its programs as requested by the cabinet secretary, commissioners or office heads.

Office of Attorney General (OAG) The Attorney General is the chief law officer of the Commonwealth of Kentucky and all of its departments, commissions, agencies, and political subdivisions, and the legal adviser of all state officers, departments, commissions, and agencies.

Out-of-Network Provider means any person or entity that has not entered into a participating provider agreement with Contractor or any of the Contractor's subcontractors for the provision of Covered Services.

Presumptive eligibility means eligibility granted for Medicaid-covered services as specified in administrative regulation as a qualified individual based on an income screening performed by a qualified provider.

Primary Care Provider or "PCP" means a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse, physician assistant, or health clinic, including an FQHC, primary care center, or RHC that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to individuals, and for a Member who has a gynecological or obstetrical health care needs, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care.

Prior Authorization means Contractor's act of authorizing specific services before they are rendered.

Program Integrity means the process of identifying and referring any suspected Fraud or Abuse activities or program vulnerabilities concerning the health care services to the Cabinet's Office of the Inspector General.

Protected Health Information (PHI) means individual patient demographic information, Claims data, insurance information, diagnosis information, and any other care or payment for health care that identifies the individual (or there is reasonable reason to believe could identify the individual), as defined by HIPAA.

Provider means any person or entity under contract with the Contractor or its contractual agent that provides Covered Services to Members.

Provider Network means collectively, all of the Providers that have contracts with the Contractor or any of the Contractor's subcontractors to provide Covered Services to Members.

Psychiatric Residential Treatment Facilities (PRTF) means a non-hospital facility that has a provider agreement with the Department to provide inpatient services to Medicaid-eligible individuals under the age of 21 who require treatment on a continuous basis as a result of a severe mental or psychiatric illness. The facility must be accredited by JCAHO or other accrediting organization with comparable standards recognized by the Commonwealth. PRTFs must also meet the requirements in §441.151 through 441.182 of the CFR.

QAPI means quality assessment and performance improvement.

Quality Improvement or QI means the process of assuring that Covered Services provided to Members are appropriate, timely, accessible, available, and Medically Necessary and the level of performance of key processes and outcomes of the healthcare delivery system are improved through the Contractor's policies and procedures.

Quality Management means the integrative process that links knowledge, structure and processes together throughout the Contractor's organization to assess and improve quality.

Rural Health Clinic or RHC means an entity that meets all of the requirements for designation as a rural health clinic under 1861(aa)(1) of the Social Security Act and approved for participation in the Kentucky Medicaid Program.

Service Location means any location at which a Member may obtain any Covered Services from the Contractor's Network Provider.

Specialty Care means any service provided that is not provided by a PCP.

State means the Commonwealth of Kentucky.

State Fair Hearing means the administrative hearing provided by the Cabinet pursuant to KRS Chapter 13B and contained in 907 KAR 17.010.

Supplemental Security Income (SSI) is a program administered by the Social Security Administration (SSA) that pays benefits to disabled adults and children who have limited income and resources. SSI benefits are also payable to people 65 and older without disability who meet the financial limits.

Teaching hospital means a hospital providing the services of interns or residents-in-training under a teaching program approved by the appropriate approving body of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. In the case of interns or residents-in-training in the field of dentistry in a general or osteopathic hospital, the teaching program shall have the approval of the Council on Dental Education of the American Dental Association. In the case of interns or resident-in-training in the field of podiatry in a general or osteopathic hospital, the teaching program shall have the approval of the Council on Podiatry Education of the American Podiatry Association.

Third-Party Liability/Resource means any resource available to a Member for the payment of expenses associated with the provision of Covered Services, including but not limited to, Medicare, other health insurance coverage or amounts recovered as a result of settlement, dispute resolution, award or litigation. Third Party Resources do not include amounts that are exempt under Title XIX of the Social Security Act.

Urgent Care means care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

Women, Infants and Children (WIC) means a federally-funded health and nutrition program for women, infants, and children.

2. Abbreviations and Acronyms

ADA - American Dental Association

AHRQ - Agency for Health Care Research and Quality

AIDS - Acquired Immune Deficiency Syndrome

APRN - Advanced Practice Registered Nurse

BBA - Balanced Budget Act

BH - Behavioral Health

CAHPS - Consumer Assessment of Health Care Providers and Systems

CAP - Corrective Action Plan

CCD - Continuity of Care Document

CFR - Code of Federal Regulations

CHFS - Cabinet for Health and Family Services

CMHC - Community Mental Health Center

CMS - Centers for Medicare and Medicaid Services

CMS-416 - Centers for Medicare and Medicaid Services-416 (form)

CMS-1500 - Centers for Medicare and Medicaid Services-1500 (form)

COB - Coordination of Benefits

COPD - Chronic Obstructive Pulmonary Disease

CPT - Current Procedural Terminology

DIVERTS - Direct Intervention: Vital Early Responsive Treatment Systems

DSH - Disproportionate Share Hospital

DSM-V - Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

EEO - Equal Employment Opportunity

EPSDT- Early Periodic Screening, Diagnostic and Treatment

EQR - External Quality Review

EQRO - External Quality Review Organization

FQHC - Federally Qualified Health Center

FTE - Full-time Equivalent

HCPCS - Health Care Common Procedure Coding System

HEDIS - Health Care Effectiveness Data and Information Set

HIPAA - Health Insurance Portability and Accountability Act

HIV - Human Immunodeficiency Virus

HRA - Health Risk Assessment

HTTP - Hyper Text Transport Protocol or Hyper Text Transfer Protocol

ICD-9-CM - International Classification of Diseases, Ninth Revision, Clinical Modification

ICD-10-CM - International Classification of Diseases, Tenth Revision, Clinical Modification

ICF-MR - Intermediate Care Facility for Mentally Retarded

IPRO- Island Peer Review Organization

KAR - Kentucky Administrative Regulation

KRS - Kentucky Revised Statute

LPN - Licensed Practical Nurse

MCO - Managed Care Organization

MBHO - Managed Behavioral Healthcare Organization

MMIS - Medicaid Management Information System

NCCI – National Correct Coding Initiative

NCPDP - National Council for Prescription Drug Programs

NCQA - National Committee for Quality Assurance

NDC - National Drug Code

OSCAR – Online Survey Certification and Reporting

PA – Prior Authorization

PCP - Primary Care Provider

PIP- Performance Improvement Project

PRTF - Psychiatric Residential Treatment Facility

QAPI - Quality Assessment and Performance Improvement

RAC – Recovery Audit Contractor

RFP - Request for Proposal

RHC - Rural Health Clinic

RN - Registered Nurse

SOBRA - Sixth Omnibus Budget Reconciliation Act

SSI - Supplemental Security Income

TANF - Temporary Assistance for Needy Families

TPL - Third Party Liability

UB-92 - Universal Billing 1992 (form)

UB-04 - Universal Billing 2004 (form)

UM - Utilization Management

URAC - Utilization Review Accreditation Commission

USC - United States Code

WIC - Women, Infants and Children