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| Section IV - Glossary400.000 | 11-1-23 |
| AAFP | American Academy of Family Physicians |
| AAP | American Academy of Pediatrics |
| ABESPA | Arkansas Board of Examiners in Speech-Language Pathology and Audiology |
| ABHSCI | Adult Behavioral Health Services for Community Independence |
| ACD | Augmentative Communication Device |
| ACIP | Advisory Committee on Immunization Practices |
| ACES | Arkansas Client Eligibility System |
| ACS | Alternative Community Services |
| ADDT | Adult Developmental Day Treatment |
| ADE | Arkansas Department of Education |
| ADH | Arkansas Department of Health  |
| ADL | Activities of Daily Living |
| AFDC | Aid to Families with Dependent Children (cash assistance program replaced by the Transitional Employment Assistance (TEA) program) |
| AHEC | Area Health Education Centers |
| ALF | Assisted Living Facilities |
| ALS | Advance Life Support |
| ALTE | Apparent Life-Threatening Events |
| AMA | American Medical Association |
| APD | Adults with Physical Disabilities |
| ARS | Arkansas Rehabilitation Services |
| ASC | Ambulatory Surgical Centers |
| ASHA | American Speech-Language-Hearing Association |
| BIPA | Benefits Improvement and Protection Act |
| BLS | Basic Life Support |
| CARF | Commission on Accreditation of Rehabilitation Facilities |
| CCRC | Children’s Case Review Committee |
| CFA | One Counseling and Fiscal Agent |
| CFR | Code of Federal Regulations |
| CLIA | Clinical Laboratory Improvement Amendments |
| CME | Continuing Medical Education |
| CMHC | Community Mental Health Center |
| CMS | Centers for Medicare and Medicaid Services  |
| COA | Council on Accreditation |
| CON | Certification of Need |
| CPT  | Physicians’ Current Procedural Terminology |
| CRNA | Certified Registered Nurse Anesthetist |
| CSHCN | Children with Special Health Care Needs |
| CSWE | Council on Social Work Education |
| D&E | Diagnosis and Evaluation |
| DAAS | Division of Aging and Adult Services |
| DBS | Division of Blind Services (currently named Division of Services for the Blind) |
| DCFS | Division of Children and Family Services |
| DCO  | Division of County Operations |
| DD | Developmentally Disabled |
| DDS | Developmental Disabilities Services |
| DHS | Department of Human Services  |
| DLS | Daily Living Skills |
| DME | Durable Medical Equipment |
| DMHS | Division of Mental Health Services |
| DMS | Division of Medical Services (Medicaid) |
| DOS | Date of Service |
| DPSQA | Division of Provider Services and Quality Assurance |
| DRG | Diagnosis Related Group |
| DRS | Developmental Rehabilitative Services |
| DDSCES | Developmental Disabilities Services Community and Employment Support |
| DSB | Division of Services for the Blind (formerly Division of Blind Services) |
| DSH | Disproportionate Share Hospital |
| DURC | Drug Utilization Review Committees |
| DYS | Division of Youth Services |
| EIDT | Early Intervention Day Treatment |
| EAC | Estimated Acquisition Cost |
| EFT | Electronic Funds Transfer |
| EIN | Employer Identification Number |
| EOB | Explanation of Benefits |
| EOMB | Explanation of Medicaid Benefits. EOMB may also refer to Explanation of Medicare Benefits. |
| EPSDT | Early and Periodic Screening, Diagnosis, and Treatment |
| ESC | Education Services Cooperative |
| FEIN | Federal Employee Identification Number |
| FPL | Federal Poverty Level |
| FQHC | Federally Qualified Health Center |
| GME | Graduate Medical Education |
| GUL | Generic Upper Limit |
| HCBS | Home and Community Based Services |
| HCPCS | Healthcare Common Procedure Coding System |
| HDC | Human Development Center |
| HHS | The Federal Department of Health and Human Services |
| HIC Number | Health Insurance Claim Number |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| HMO | Health Maintenance Organization |
| IADL | Instrumental Activities of Daily Living |
| ICD | International Classification of Diseases |
| ICF/IID | Intermediate Care Facility for Individuals with Intellectual Disabilities |
| ICN | Internal Control Number |
| IDEA | Individuals with Disabilities Education Act |
| IDG | Interdisciplinary Group |
| IEP | Individualized Educational Program |
| IFSP | Individualized Family Service Plan |
| IMD | Institution for Mental Diseases |
| IPP | Individual Program Plan |
| IUD | Intrauterine Devices |
| JCAHO | Joint Commission on Accreditation of Healthcare Organization |
| LAC | Licensed Associate Counselor |
| LCSW | Licensed Certified Social Worker |
| LEA | Local Education Agencies |
| LMFT | Licensed Marriage and Family Therapist |
| LPC | Licensed Professional Counselor |
| LPE | Licensed Psychological Examiner |
| LSPS | Licensed School Psychology Specialist |
| LTC | Long Term Care |
| MAC | Maximum Allowable Cost |
| MAPS | Multi-agency Plan of Services |
| MART | Medicaid Agency Review Team |
| MEI | Medicare Economic Index |
| MMIS | Medicaid Management Information System |
| MNIL | Medically Needy Income Limit |
| MPPPP | Medicaid Prudent Pharmaceutical Purchasing Program |
| MSA | Metropolitan Statistical Area |
| MUMP | Medicaid Utilization Management Program |
| NBCOT | National Board for Certification of Occupational Therapy |
| NCATE | North Central Accreditation for Teacher Education |
| NDC  | National Drug Code |
| NET | Non-Emergency Transportation Services |
| NF | Nursing Facility |
| NPI | National Provider Identifier |
| OBRA | Omnibus Budget Reconciliation Act |
| OHCDS | Organized Health Care Delivery System |
| OBHS | Outpatient Behavioral Health Services |
| OTC | Over the Counter |
| PA | Prior Authorization |
| PAC | Provider Assistance Center |
| PASSE | Provider-led Arkansas Shared Savings Entity Program |
| PCP | Primary Care Physician |
| PERS | Personal Emergency Response Systems |
| PHS | Public Health Services |
| PIM | Provider Information Memorandum |
| PL | Public Law |
| POC | Plan of Care |
| POS | Place of Service  |
| PPS | Prospective Payment System |
| PRN | Pro Re Nata or “As Needed” |
| PRO | Professional Review Organization |
| ProDUR | Prospective Drug Utilization Review |
| QIDP | Qualified Intellectual Disabilities Professional |
| QMB | Qualified Medicare Beneficiary |
| RA | Remittance Advice. Also called Remittance and Status Report |
| RFP | Request for Proposal |
| RHC | Rural Health Clinic |
| BID | Beneficiary Identification Number |
| RSPD | Rehabilitative Services for Persons with Physical Disabilities |
| RSYC | Rehabilitative Services for Youth and Children |
| RTC | Residential Treatment Centers |
| RTP | Return to Provider |
| RTU | Residential Treatment Units |
| SBMH  | School-Based Mental Health Services |
| SD | Spend Down |
| SFY | State Fiscal Year |
| SMB | Special Low-Income Qualified Medicare Beneficiaries |
| SNF | Skilled Nursing Facility |
| SSA  | Social Security Administration |
| SSI | Supplemental Security Income |
| SURS | Surveillance and Utilization Review Subsystem |
| TCM | Targeted Case Management |
| TEA | Transitional Employment Assistance |
| TEFRA | Tax Equity and Fiscal Responsibility Act |
| TOS | Type of Service |
| TPL | Third Party Liability |
| UPL | Upper Payment Limit |
| UR | Utilization Review |
| VFC | Vaccines for Children |
| VRS | Voice Response System |
| Accommodation | A type of hospital room, e.g., private, semiprivate, ward, etc. |
| Activities of Daily Living (ADL) | Personal tasks that are ordinarily performed daily and include eating, mobility/transfer, dressing, bathing, toileting, and grooming |
| Adjudicate | To determine whether a claim is to be paid or denied |
| Adjustments | Transactions to correct claims paid in error or to adjust payments from a retroactive change |
| Admission | Actual entry and continuous stay of the beneficiary as an inpatient to an institutional facility |
| Affiliates | Persons having an overt or covert relationship such that any individual directly or indirectly controls or has the power to control another individual |
| Agency | The Division of Medical Services |
| Aid Category | A designation within SSI or state regulations under which a person may be eligible for public assistance |
| Aid to Families with Dependent Children (AFDC) | A Medicaid eligibility category |
| Allowed Amount | The maximum amount Medicaid will pay for a service as billed before applying beneficiary coinsurance or co-pay, previous TPL payment, spend down liability, or other deducted charges |
| American Medical Association (AMA) | National association of physicians |
| Ancillary Services | Services available to a patient other than room and board. For example: pharmacy, X-ray, lab, and central supplies  |
| Arkansas Client Eligibility System (ACES) | A state computer system in which data is entered to update assistance eligibility information and beneficiary files |
| Attending Physician  | *See Performing Physician*. |
| Automated Eligibility Verification Claims Submission (AEVCS) | Online system for providers to verify eligibility of beneficiaries and submit claims to fiscal agent |
| Base Charge | A set amount allowed for a participating provider according to specialty |
| Beneficiary | Person who meets the Medicaid eligibility requirements, receives an ID card, and is eligible for Medicaid services (formerly recipient) |
| Benefits | Services available under the Arkansas Medicaid Program |
| Billed Amount | The amount billed to Medicaid for a rendered service |
| Buy-In  | A process whereby the state enters into an agreement with the Medicaid/Medicare and the Social Security Administration to obtain Medicare Part B (and part A when needed) for Medicaid beneficiaries who are also eligible for Medicare. The state pays the monthly Medicare premium(s) on behalf of the beneficiary. |
| Caregiver | An individual who has responsibility for the protection, in-home care, or custody of a Medicaid enrollee as a result of assuming the responsibility by contract. |
| Care Plan | *See Plan of Care (POC).* |
| Case Head  | An adult responsible for an AFDC or Medicaid child |
| Categorically Needy | All individuals receiving financial assistance under the state’s approved plan under Title I, IV-A, X, XIV, and XVI of the Social Security Act or in need under the state’s standards for financial eligibility in such a plan |
| Centers for Medicare and Medicaid Services | Federal agency that administers federal Medicaid funding |
| Child Health Services | Arkansas Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program |
| Children with Chronic Health Conditions (CHC)  | A Title V Children with Special Health Care Needs Program administered by the Arkansas Division of Developmental Disabilities Services to provide medical care and service coordination to children with chronic physical illnesses or disabilities. |
| Claim | A request for payment for services rendered |
| Claim Detail  | *See Line Item*. |
| Clinic  | (1) A facility for diagnosis and treatment of outpatients. (2) A group practice in which several physicians work together |
| Coinsurance  | The portion of allowed charges the patient is responsible for under Medicare. This may be covered by other insurance, such as Medi-Pak or Medicaid (if entitled). This also refers to the portion of a Medicaid covered inpatient hospital stay for which the beneficiary is responsible. |
| Contract | Written agreement between a provider of medical services and the Arkansas Division of Medical Services. A contract must be signed by each provider of services participating in the Medicaid Program. |
| Co-pay | The portion of the maximum allowable (either that of Medicaid or a third-party payer) that the insured or beneficiary must pay |
| Cosmetic Surgery | Any surgical procedure directed at improving appearance but not medically necessary |
| Covered Service | Service which is within the scope of the Arkansas Medicaid Program  |
| Current Procedural Terminology  | A listing published annually by AMA consisting of current medical terms and the corresponding procedure codes used for reporting medical services and procedures performed by physicians |
| Credit Claim  | A claim transaction which has a negative effect on a previously processed claim. |
| Crossover Claim | A claim for which both Titles XVIII (Medicare) and XIX (Medicaid) are liable for reimbursement of services provided to a beneficiary entitled to benefits under both programs |
| Date of Service | Date or dates on which a beneficiary receives a covered service. Documentation of services and units received must be in the beneficiary’s record for each date of service. |
| Deductible  | The amount the Medicare beneficiary must pay toward covered benefits before Medicare or insurance payment can be made for additional benefits. Medicare Part A and Part B deductibles are paid by Medicaid within the program limits. |
| Debit Claim  | A claim transaction which has a positive effect on a previously processed claim |
| Denial  | A claim for which payment is disallowed |
| Department of Health and Human Services (HHS) | Federal health and human services agency |
| Department of Human Services (DHS) | State human services agency  |
| Dependent | A spouse or child of the individual who is entitled to benefits under the Medicaid Program |
| Diagnosis | The identity of a condition, cause, or disease |
| Diagnostic Admission  | Admission to a hospital primarily for the purpose of diagnosis |
| Disallow | To subtract a portion of a billed charge that exceeds the Medicaid maximum or to deny an entire charge because Medicaid pays Medicare Part A and B deductibles subject to program limitations for eligible beneficiaries |
| Discounts | A discount is defined as the lowest available price charged by a provider to a client or third-party payer, including any discount, for a specific service during a specific period by an individual provider. If a Medicaid provider offers a professional or volume discount to any customer, claims submitted to Medicaid must reflect the same discount.Example: If a laboratory provider charges a private physician or clinic a discounted rate for services, the charge submitted to Medicaid for the same service must not exceed the discounted price charged to the physician or clinic. Medicaid must be given the benefit of discounts and price concessions the lab gives any of its customers. |
| Duplicate Claim | A claim that has been submitted or paid previously or a claim that is identical to a claim in process  |
| Durable Medical Equipment | Equipment that (1) can withstand repeated use and (2) is used to serve a medical purpose. Examples include a wheelchair or hospital bed. |
| Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) | A federally mandated Medicaid program for eligible individuals under the age of twenty-one (21). *See Child Health Services*. |
| Education Accreditation | When an individual is required to possess a bachelor’s degree, master’s degree, or a Ph.D. degree in a specific profession. The degree must be from a program accredited by an organization that is approved by the Council for Higher Education Accreditation (CHEA). |
| Electronic Signature | An electronic or digital method executed or adopted by a party with the intent to be bound by or to authenticate a record, which is: (a) Unique to the person using it; (b) Capable of verification; (c) Under the sole control of the person using it; and (d) Linked to data in such a manner that if the data are changed the electronic signature is invalidated. An Electronic Signature method must be approved by the DHS Chief Information Officer or his or her designee before it will be accepted. A list of approved electronic signature methods will be posted on the state Medicaid website. |
| Eligible | (1) To be qualified for Medicaid benefits. (2) An individual who is qualified for benefits |
| Eligibility File | A file containing individual records for all persons who are eligible or have been eligible for Medicaid |
| Emergency Services | Inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.Source: 42 U.S. Code of Federal Regulations (42 CFR) and §424.101. |
| Error Code | A numeric code indicating the type of error found in processing a claim also known as an “Explanation of Benefits (EOB) code” or a “HIPAA Explanation of Benefits (HEOB) code” |
| Estimated Acquisition Cost | The estimated amount a pharmacy actually pays to obtain a drug |
| Experimental Surgery | Any surgical procedure considered experimental in nature |
| Explanation of Medicaid Benefits (EOMB) | A statement mailed once per month to selected beneficiaries to allow them to confirm the Medicaid service which they received |
| Family Planning Services | Any medically approved diagnosis, treatment, counseling, drugs, supplies, or devices prescribed or furnished by a physician, nurse practitioner, certified nurse-midwife, pharmacy, hospital, family planning clinic, rural health clinic (RHC), Federally Qualified Health Center (FQHC), or the Department of Health to individuals of child-bearing age for purposes of enabling such individuals freedom to determine the number and spacing of their children. |
| Field Audit | An activity performed whereby a provider’s facilities, procedures, records, and books are audited for compliance with Medicaid regulations and standards. A field audit may be conducted on a routine basis, or on a special basis announced or unannounced. |
| Fiscal Agent  | An organization authorized by the State of Arkansas to process Medicaid claims |
| Fiscal Agent Intermediary  | A private business firm which has entered into a contract with the Arkansas Department of Human Services to process Medicaid claims |
| Fiscal Year | The twelve-month period between settlements of financial accounts |
| Generic Upper Limit (GUL) | The maximum drug cost that may be used to compute reimbursement for specified multiple-source drugs unless the provisions for a Generic Upper Limit override have been met. The Generic Upper Limit may be established or revised by the Centers for Medicare and Medicaid Services (CMS) or by the State Medicaid Agency.  |
| Group | Two (2) or more persons. If a service is a “group” therapy or other group service, there must be two (2) or more persons present and receiving the service. |
| Group Practice | A medical practice in which several practitioners render and bill for services under a single pay-to provider identification number |
| Healthcare Common Procedure Coding System (HCPCS) | Federally defined procedure codes |
| Health Insurance Claim Number | Number assigned to Medicare beneficiaries and individuals eligible for SSI |
| Hospital  | An institution that meets the following qualifications:* Provides diagnostic and rehabilitation services to inpatients
* Maintains clinical records on all patients
* Has by-laws with respect to its staff of physicians
* Requires each patient to be under the care of a physician, dentist, or certified nurse-midwife
* Provides 24-hour nursing service
* Has a hospital utilization review plan in effect
* Is licensed by the State
* Meets other health and safety requirements set by the Secretary of Health and Human Services
 |
| Hospital-Based Physician | A physician who is a hospital employee and is paid for services by the hospital |
| ID Card | An identification card issued to Medicaid beneficiaries and ARKids First-B participants containing encoded data that permits a provider to access the card-holder’s eligibility information |
| Individual | A single person as distinguished from a group. If a service is an “individual” therapy or service, there may be only one (1) person present who is receiving the service. |
| Inpatient | A patient, admitted to a hospital or skilled nursing facility, who occupies a bed and receives inpatient services. |
| In-Process Claim (Pending Claim) | A claim that suspends during system processing for suspected error conditions such as: all processing requirements appear not to be met. These conditions must be reviewed by the Arkansas Medicaid fiscal agent or DMS and resolved before processing of the claim can be completed. *See Suspended Claim*. |
| Inquiry | A request for information |
| Institutional Care  | Care in an authorized private, non-profit, public, or state institution or facility. Such facilities include schools for the deaf, or blind and institutions for individuals with disabilities. |
| Instrumental Activities of Daily Living (IADL) | Tasks which are ordinarily performed on a daily or weekly basis and include meal preparation, housework, laundry, shopping, taking medications, and travel/transportation  |
| Intensive Care | Isolated and constant observation care to patients critically ill or injured |
| Interim Billing | A claim for less than the full length of an inpatient hospital stay. Also, a claim that is billed for services provided to a particular date even though services continue beyond that date. It may or may not be the final bill for a particular beneficiary’s services. |
| Internal Control Number (ICN) | The unique 13-digit claim number that appears on a Remittance Advice |
| International Classification of Diseases | A diagnosis coding system used by medical providers to identify a patient’s diagnosis or diagnoses on medical records and claims |
| Investigational Product | Any product that is considered investigational or experimental and that is not approved by the Food and Drug Administration. The Arkansas Medicaid Program does not cover investigational products but does cover routine standard of care associated with qualifying clinical trials. |
| Julian Date  | Chronological date of the year, 001 through 365 or 366, preceded on a claims number (ICN) by a two-digit-year designation. Claim number example: 03231 (August 19, 2003). |
| Length of Stay | Period of time a patient is in the hospital. Also, the number of days covered by Medicaid within a single inpatient stay. |
| Limited Services Provider Agreement | An agreement for a specific period of time not to exceed twelve (12) months, which must be renewed in order for the provider to continue to participate in the Title XIX Program. |
| Line Item | A service provided to a beneficiary. A claim may be made up of one (1) or more line items for the same beneficiary. Also called a claim detail. |
| Long Term Care (LTC) | An office within the Arkansas Division of Medical Services responsible for nursing facilities |
| Long Term Care Facility  | A nursing facility |
| Maximum Allowable Cost (MAC) | The maximum drug cost which may be reimbursed for specified multi-source drugs. This term is interchangeable with generic upper limit. |
| Medicaid Provider Number | A unique identifying number assigned to each provider of services in the Arkansas Medicaid Program, required for identification purposes  |
| Medicaid Management Information System (MMIS) | The automated system utilized to process Medicaid claims |
| Medical Assistance Section | A section within the Arkansas Division of Medical Services responsible for administering the Arkansas Medical Assistance Program |
| Medically Needy | Individuals whose income and resources exceed the levels for assistance established under a state or federal plan for categorically needy, but are insufficient to meet costs of health and medical services  |
| Medical Necessity | All Medicaid benefits are based upon medical necessity. A service is “medically necessary” if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a “course of treatment” may include mere observation or (where appropriate) no treatment at all. The determination of medical necessity may be made by the Medical Director for the Medicaid Program or by the Medicaid Program Quality Improvement Organization (QIO). Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as inappropriate or ineffective unless objective clinical evidence demonstrates circumstances making the service necessary. |
| Mis-Utilization | Any usage of the Medicaid Program by any of its providers or beneficiaries which is not in conformance with both State and Federal regulations and laws (including, but not limited to, fraud, abuse, and defects in level and quality of care) |
| National Drug Code | The unique 11-digit number assigned to drugs which identifies the manufacturer, drug, strength, and package size of each drug |
| National Provider Identifier (NPI) | A standardized unique health identifier for health care providers for use in the health care system in connection with standard transactions for all covered entities. Established by the Centers for Medicare & Medicaid Services, HHS, in compliance with HIPAA Administrative Simplification – 45 CFR Part 162. |
| Non-Covered Services | Services not medically necessary, services provided for the personal convenience of the patient or services not covered under the Medicaid Program |
| Nonpatient | An individual who receives services, such as laboratory tests, performed by a hospital, but who is not a patient of the hospital |
| Nurse Practitioner | A professional nurse with credentials that meet the requirements for licensure as a nurse practitioner in the State of Arkansas |
| Outpatient | A patient receiving medical services, but not admitted as an inpatient to a hospital |
| Over-Utilization | Any over usage of the Medicaid Program by any of its providers or beneficiaries not in conformance with professional judgment and both State and Federal regulations and laws (including, but not limited to, fraud and abuse) |
| Participant | A provider of services who: (1) provides the service, (2) submits the claim and (3) accepts Medicaid’s reimbursement for the services provided as payment in full |
| Patient | A person under the treatment or care of a physician or surgeon, or in a hospital |
| Payment | Reimbursement to the provider of services for rendering a Medicaid-covered benefit |
| Pay-to Provider | A person, organization, or institution authorized to receive payment for services provided to Medicaid beneficiaries by a person or persons who are a part of the entity |
| Pay-to Provider Number | A unique identifying number assigned to each pay-to provider of services (Clinic/Group/Facility) in the Arkansas Medicaid Program or the pay-to provider group’s assigned National Provider Identifier (NPI). Medicaid reports provider payments to the Internal Revenue Service under the Employer Identification Number “Tax ID” linked in the Medicaid Provider File to the pay-to provider identification number. |
| Per Diem | A daily rate paid to institutional providers |
| Performing Physician | The physician providing, supervising, or both, a medical service and claiming primary responsibility for ensuring that services are delivered as billed |
| Person | Any natural person, company, firm, association, corporation, or other legal entity |
| Place of Service (POS) | A nationally approved two-digit numeric code denoting the location of the patient receiving services |
| Plan of Care | A document utilized by a provider to plan, direct, or deliver care to a patient to meet specific measurable goals; also called care plan, service plan, or treatment plan |
| Postpayment Utilization Review | The review of services, documentation, and practice after payment |
| Practitioner | An individual who practices in a health or medical service profession |
| Prepayment Utilization Review | The review of services, documentation, and practice patterns before payment |
| Prescription | A health care professional’s legal order for a drug which, in accordance with federal or state statutes, may not be obtained otherwise; also, an order for a particular Medicaid covered service |
| Prescription Drug (RX) | A drug which, in accordance with federal or state statutes, may not be obtained without a valid prescription |
| Primary Care Physician (PCP) | A physician responsible for the management of a beneficiary’s total medical care. Selected by the beneficiary to provide primary care services and health education. The PCP will monitor on an ongoing basis the beneficiary’s condition, health care needs and service delivery, be responsible for locating, coordinating, and monitoring medical and rehabilitation services on behalf of the beneficiary, and refer the beneficiary for most specialty services, hospital care, and other services. |
| Prior Approval | The approval for coverage and reimbursement of specific services prior to furnishing services for a specified beneficiary of Medicaid. The request for prior approval must be made to the Medical Director of the Division of Medical Services for review of required documentation and justification for provision of service. |
| Prior Authorization (PA)  | The approval by the Arkansas Division of Medical Services, or a designee of the Division of Medical Services, for specified services for a specified beneficiary to a specified provider before the requested services may be performed and before payment will be made. **Prior authorization does not guarantee reimbursement.** |
| Procedure Code | A five-digit numeric or alpha numeric code to identify medical services and procedures on medical claims |
| Professional Component | A physician’s interpretation or supervision and interpretation of laboratory, X-ray, or machine test procedures |
| Profile | A detailed view of an individual provider’s charges to Medicaid for health care services or a detailed view of a beneficiary’s usage of health care services |
| Provider | A person, organization, or institution enrolled to provide and be reimbursed for health or medical care services authorized under the State Title XIX Medicaid Program |
| Provider Identification Number | A unique identifying number assigned to each provider of services in the Arkansas Medicaid Program or the provider’s assigned National Provider Identifier (NPI), when applicable, that is required for identification purposes  |
| Provider Relations | The activity within the Medicaid Program which handles all relationships with Medicaid providers |
| Quality Assurance | Determination of quality and appropriateness of services rendered |
| Quality Improvement Organization | A Quality Improvement Organization (QIO) is a federally mandated review organization required of each state’s Title XIX (Medicaid) program. The QIO monitors hospital and physician services billed to the state’s Medicare intermediary and the Medicaid program to assure high quality, medical necessity, and appropriate care for each patient’s needs. |
| Railroad Claim Number | The number issued by the Railroad Retirement Board to control payments of annuities and pensions under the Railroad Retirement Act. The claim number begins with a one- to three-letter alphabetic prefix denoting the type of payment, followed by six (6) or nine (9) numeric digits.  |
| Referral | An authorization from a Medicaid enrolled provider to a second Medicaid enrolled provider. The receiving provider is expected to exercise independent professional judgment and discretion, to the extent permitted by laws and rules governing the practice of the receiving practitioner, and to develop and deliver medically necessary services covered by the Medicaid program. The provider making the referral may be a physician or another qualified practitioner acting within the scope of practice permitted by laws or rules. Medicaid requires documentation of the referral in the beneficiary’s medical record, regardless of the means the referring provider makes the referral. Medicaid requires the receiving provider to document the referral also, and to correspond with the referring provider regarding the case when appropriate and when the referring provider so requests. |
| Registry records check | The review of one (1) or more database systems maintained by a state agency that contain information relative to the suitability of a person to be a caregiver. |
| Reimbursement  | The amount of money remitted to a provider |
| Rejected Claim  | A claim for which payment is refused  |
| Relative Value  | A weighting scale used to relate the worth of one (1) surgical procedure to any other. This evaluation, expressed in units, is based upon the skill, time, and the experience of the physician in its performance. |
| Remittance | A remittance advice |
| Remittance Advice (RA) | A notice sent to providers advising the status of claims received, including paid, denied, in-process, and adjusted claims. It includes year-to-date payment summaries and other financial information. |
| Reported Charge | The total amount submitted in a claim detail by a provider of services for reimbursement |
| Retroactive Medicaid Eligibility  | Medicaid eligibility which may begin up to three (3) months prior to the date of application provided all eligibility factors are met in those months |
| Returned Claim  | A claim which is returned by the Medicaid Program to the provider for correction or change to allow it to be processed properly |
| Routine Standard of Care Associated with Qualifying Clinical Trials | Effective for items and services furnished on or after 01/01/2022, Medicaid covers the routine costs of qualifying clinical trials, as such costs are defined below, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. All other Medicaid rules apply.Routine costs of a clinical trial include all items and services that are otherwise generally available to Medicaid beneficiaries (i.e., there exists a benefit category, it is not statutorily excluded, and there is not a national non-coverage decision) that are provided in either the experimental or the control arms of a clinical trial except:The investigational item or service, itself unless otherwise covered outside of the clinical trial;* Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); and
* Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

Routine costs in clinical trials include:* Items or services that are typically provided absent a clinical trial (e.g., conventional care);
* Items or services required solely for the provision of the investigational item or service (e.g., administration of a noncovered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
* Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, for the diagnosis or treatment of complications.
 |
| Sanction  | Any corrective action taken against a provider |
| Screening  | The use of quick, simple, medical procedures carried out among large groups of people to sort out apparently well persons from those who may have a disease or abnormality and to identify those in need of more definitive examination or treatment |
| Signature | The person’s original signature or initials. The person’s signature or initials may also be recorded by an electronic or digital method, executed, or adopted by the person with the intent to be bound by or to authenticate a record. An electronic signature must comply with Arkansas Code Annotated § 25-31-101-105, including verification through an electronic signature verification company and data links invalidating the electronic signature if the data is changed. |
| Single State Agency  | The state agency authorized to administer or supervise the administration of the Medicaid Program on a statewide basis |
| Skilled Nursing Facility (SNF) | A nursing home, or a distinct part of a facility, licensed by the Office of Long-Term Care as meeting the Skilled Nursing Facility Federal/State licensure and certification regulations. A health facility which provides skilled nursing care and supportive care on a 24-hour basis to residents whose primary need is for availability of skilled nursing care on an extended basis. |
| Social Security Administration (SSA)  | A federal agency which makes disability and blindness determinations for the Secretary of the HHS |
| Social Security Claim Number | The account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is the Social Security Account Number followed by a suffix, sometimes as many as three (3) characters, designating the type of beneficiary (e.g., wife, widow, child, etc.). |
| Source of Care  | A hospital, clinic, physician, or other facility which provides services to a beneficiary under the Medicaid Program  |
| Specialty  | The specialized area of practice of a physician or dentist  |
| Spend Down (SD)  | The amount of money a beneficiary must pay toward medical expenses when income exceeds the Medicaid financial guidelines. A component of the medically needy program allows an individual or family whose income is over the medically needy income limit (MNIL) to use medical bills to spend excess income down to the MNIL. The individual(s) will have a spend down liability. The spend down column of the remittance advice indicates the amount which the provider may bill the beneficiary. The spend down liability occurs only on the first day of Medicaid eligibility. |
| Status Report | A remittance advice |
| Supplemental Security Income (SSI) | A program administered by the Social Security Administration. This program replaced previous state administered programs for aged, blind, or individuals with disabilities (except in Guam, Puerto Rico, and the Virgin Islands). This term may also refer to the Bureau of Supplemental Security Income within SSA which administers the program. |
| Suspended Claim | An “In-Process Claim” which must be reviewed and resolved |
| Suspension from Participation | An exclusion from participation for a specified period |
| Suspension of Payments | The withholding of all payments due to a provider until the resolution of a matter in dispute between the provider and the state agency  |
| Termination from Participation | A permanent exclusion from participation in the Title XIX Program |
| Third Party Liability (TPL) | A condition whereby a person or an organization, other than the beneficiary or the state agency, is responsible for all or some portion of the costs for health or medical services incurred by the Medicaid beneficiary (e.g., a health insurance company, a casualty insurance company, or another person in the case of an accident, etc.). |
| Utilization Review (UR) | The section of the Arkansas Division of Medical Services which performs the monitoring and controlling of the quantity and quality of health care services delivered under the Medicaid Program |
| Void | A transaction which deletes |
| Voice Response System (VRS) | Voice-activated system to request prior authorization for prescription drugs and for PCP assignment and change  |
| Ward | An accommodation of five (5) or more beds  |
| Withholding of Payments | A reduction or adjustment of the amounts paid to a provider on pending and subsequently due payments |
| Worker’s Compensation | A type of Third-Party Liability for medical services rendered as the result of an on-the-job accident or injury to a beneficiary for which the employer’s insurance company may be obligated under the Worker’s Compensation Act |