

POLICY MANUAL DEFINITIONS

1. **ABD**
Aged, blind and disabled
2. **Acute Care Services**
Medically necessary services as described in this Manual that are covered for Medicaid recipients who are eligible for services. The services are provided through contractual agreements with program contractors or on a fee for service basis.
3. **Allowance**
The amount paid by Medicaid for health care or a service.
4. **AMA**
American Medical Association
5. **Applicant**
An individual who completes and signs the Med-QUEST application form on behalf of himself or herself and/or other family dependents.
6. **Attending Physician**
A physician (M.D.) or a doctor of osteopathy (O.D./D.O.) who is identified by the individual as having the most significant role in the determination and delivery of the individual's medical care.
7. **Behavioral Health Managed Care Plan**
The DHS contracted managed care plan that provides behavioral health services with a focus on case management to enrolled seriously mentally ill (SMI) adults.
8. **Behavioral Health Services**
Services provided to persons who are emotionally disturbed, mentally ill, abuse or are addicted to alcohol and drugs.
9. **Benefits**
Those health services to which the recipient is entitled under Medicaid.
10. **Charge**
The amount charged by the provider for services rendered to a recipient.

- 11. Claim**
A legal document submitted to Medicaid or its fiscal agent for payment.
- 12. Clean Claim**
A claim that does not require further written information or substantiation in order to make payment.
- 13. CMS**
The Centers for Medicare and Medicaid Services formerly referred to as HCFA. The new organization is grouped into three centers; the Center for Beneficiary Choices (Medicare Choice Plus), the Center for Medicare Management (FFS Medicare), and the Center for Medicaid and State Operations (State administered programs including Medicaid, S-CHIP, and insurance regulation).
- 14. Covered Services**
Those services and benefits to which the recipient is entitled under a medical assistance program.
- 15. CPT-4**
Common Procedural Terminology, a coding structure for medical procedures issued by the American Medical Association.
- 16. Crisis**
A period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.
- 17. Days**
Calendar days
- 18. Dental Emergency**
An oral condition requiring immediate dental services to control bleeding, eliminate acute infection, treat injuries to teeth or supportive structures, or provide palliative treatment without delay.
- 19. Dependent**
A recipient's legal spouse or dependent child who meets all eligibility requirements.
- 20. Dependent Child**
A child under 19 for whom an applicant or recipient is legally responsible.

- 21. DHS**
Department of Human Services, the State Agency responsible for administering Medicaid for Hawaii.
- 22. Director**
Director of the Department of Human Services, State of Hawaii.
- 23. DSM IV**
Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.
- 24. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**
EPSDT is a federally mandated program for children up to age 21 which emphasizes the importance of prevention, early detection of medical, dental and behavioral health conditions and timely treatment of conditions detected as a result of screening.
- 25. Effective Date of Enrollment**
The date from which an individual is covered by Medicaid.
- 26. Eligibility Determination**
A process of determining, upon receipt of written application, whether an individual or family is eligible for benefits such as health services.
- 27. Eligible Person**
A person who has been determined to qualify for health services pursuant to regulations but who is not enrolled in a health plan or with a program contractor. (Also see definition for recipient.)
- 28. EMC**
Electronic media claim
- 29. Emergency Condition**
A medical condition manifesting itself by acute symptoms of sufficient severity (including sever pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part.
- 30. Emergency Medical Service**
Medical services provided after the sudden onset of an emergency medical condition and resulting in an unscheduled or unplanned visit, admission or other medical services to assess, relieve and/or treat the emergent condition.

- 31. Explanation of Benefits (EOB)**
The statement mailed to providers detailing the claims paid or denied, including explanations for those denied.
- 32. Fee-For-Service (FFS)**
A method of payment when a physician or other health care provider bills and is paid for each service. Also refers to services reimbursed directly by the Med-QUEST Division for eligible persons not enrolled with a health plan or program contractor. See definition of Recipient for individuals enrolled with the FFS Program.
- 33. FQHC**
Federally qualified health center
- 34. Fiscal Year or FY**
The twelve month period for the State fiscal year from July 1 through June 30.
- 35. HAWI**
Hawaii Automated Welfare Information System. The State of Hawaii certified system, which maintains eligibility information for TANF, Food Stamp and medical assistance recipients.
- 36. HCFA**
Formerly stood for the Health Care Financing Administration, U.S. Department of Health and Human Services which was responsible for administering Medicaid. The new name for HCFA is Centers for Medicare and Medicaid Services (CMS).
- 37. HCFA 1500**
Nationally accepted claim form for non-institutional billing, excluding dental and pharmacy claims.
- 38. HCPCS**
Health Care Financing Administration's Common Procedure Coding System, created by HCFA and required when reporting procedures and services provided to Medicare and Medicaid beneficiaries; includes HCFA and CPT codes.
- 39. Health Assessment**
An evaluation of the health status of an individual, including an evaluation of the individual's lifestyle and need for continuing health services.

- 40. Health Plan**
Any health care organization, insurance company or health maintenance organization, which provides covered services on a risk basis to enrollees in exchange for premium payments.
- 41. Home and Community Based Services**
Waiver services provided, in lieu of institutionalization, to Medicaid recipients who reside in their own home or in an approved alternative residential setting in order to habilitate, rehabilitate or maintain the recipient's highest level of functioning.
- 42. Hospice Services**
Palliative and supportive services provided to terminally ill recipients through an agency or organization licensed and Medicare certified as a hospice. Services may be provided to recipients in their own home, an approved alternative residential setting, or an institutional setting.
- 43. Hospital**
Any hospital in the service area to which a recipient is admitted to receive hospital services pursuant to arrangements made by a physician.
- 44. Hospital Services**
Except as expressly limited or excluded in the manual or contract, those medically necessary services for registered bed patients that are generally and customarily provided by acute care general hospitals in the service area and prescribed, directed or authorized by the attending physician.
- 45. ICD-9-CM**
International Classification of Diseases, Ninth Edition – Clinical Modification, a classification system and coding structure of diseases.
- 46. Length of Stay**
The number of days for which inpatient services are provided, including the day of admission and excluding the day of discharge.
- 47. Medicaid**
A Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching grants for a medical assistance program for recipients of federally aided public assistance and SSI benefits and other specified groups.
- 48. Medical Office**
Any outpatient treatment facility staffed by a physician.

49. Medical Services

Except as expressly limited or excluded by contract, those medically necessary professional services of physicians, other health professionals and paramedical personnel that are generally and customarily provided in the service area and performed, prescribed or directed by the attending physician.

50. Medically Necessary

Those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law that follows standard medical practice and is deemed essential and appropriate for the diagnosis or treatment of a particular illness or injury.

51. Medicare

A federally funded program that primarily provides medical coverage for persons who are 65 years of age and older, disabled, or have end-stage renal disease (ESRD).

52. Months

Calendar months.

53. Outpatient Hospital

Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital for the care of a patient who is not a registered bed patient (i.e. not admitted to acute inpatient care).

54. Own Home

The Medicaid recipient's place of residence pursuant to regulations. This does not include approved alternative residential settings.

56. Physician

The physician is licensed in Hawaii and is either a M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy).

57. Plan of Care

The proposed, individualized regimen of services, which is prepared by the service provider and includes measurable goals and objectives for the outcome of services.

58. Prepaid Plan

A health plan for which premiums are paid on a prospective basis, irrespective of the use of services.

- 59. Prior Authorization (PA)**
Process by which health plans, program contractors, and the Med-QUEST Division determine in advance whether a medical service is appropriate and will be covered for payment.
- 60. Private Health Insurance Policy**
Any health insurance program, other than disease-specific or accident-only policy, for which a person pays for insurance benefits directly to the carrier rather than through participation in an employer or union, sponsored program.
- 61. Program Contractor**
An organization, which contracts with the Med-QUEST Division to execute the provision of a comprehensive package of services to recipients, enrolled with the program contractor.
- 62. Provider**
An individual, clinic, or institution, including but not limited to physicians, osteopaths, nurses, and hospitals responsible for the provision of health services.
- 63. Recipient**
Any individual or family dependent who meets all eligibility requirements and is enrolled in Med-QUEST.
- 64. Representative**
A person who is, because of the recipient's mental or physical incapacity, authorized in accordance with state law to act in their stead.
- 65. Respite**
Short-term care provided to the individual only when necessary to relieve the family or other persons caring for the individual.
- 66. S-CHIP**
The State Children's Health Insurance (S-CHIP) means the program that was created through enactment of Title XXI of the Social Security Act in the Federal Balanced Budget Act of 1197. This program allows states to expand health insurance coverage for uninsured children up to age 19 with family incomes up to 200% of the federal poverty level. These children receive all the benefits of the EPSDT program.
- 67. SED**
Severely emotionally disturbed (SED) describes children from birth to age 21 whom, as the result of a mental, behavioral or emotional disorder of a sufficient duration to meet diagnostic criteria. These children exhibit functions, which interferes substantially with their family, school, or community activities.

- 68. Service Date**
Date on which a health care service was rendered by a provider to a recipient.
- 69. SMI**
Seriously mentally ill, describes adults (copy definition from BHMCO RFP)
- 70. SSI**
The Supplemental Security Income (SSI) program is administered by the Social Security Administration like Social Security through funding by the federal government and the State. SSI pays monthly benefits to people, who aside from meeting certain requirements, must be age 65 or older, blind or disabled with limited income and resources. SSI differs from Social Security benefits in that they are not based on prior work history of either the recipient or a family member.
- 71. Standard Medical Practice**
Most physicians in the nation regard the services as safe and effective. If a service is in its trial stages (e.g., experimental because it is used in research on animals or investigative because it is or has been performed on a limited number of people), the service is not considered standard medical practice for purposed of benefit payment.
- 72. State**
State of Hawaii
- 73. Suspended Claim**
A claim that requires further action or review before it is paid or denied.
- 74. TANF**
Temporary Assistance to Needy Families. Time limited public financial assistance program that replaced ADFC that provides cash grant and medical benefits to adults and children.
- 75. Terminally Ill**
A medical prognosis determined and documented by a physician that recipient's life expectancy is six months or less if the recipient's illness runs its normal course.
- 76. UB-92**
Nationally designed claim form for institutional billings.
- 77. Urgent Care**
The diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life and health but which requires medical attention within 24 hours.