APPENDIX A

DEFINITION OF TERMS

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Abuse	Practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to the Virginia Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally-recognized standards for health care.
Accommodation	A type of room; e.g., private, semiprivate, ward, etc.
Adjudicate	To determine whether a claim should be paid or disallowed.
Adjustments	Changes made to correct an error in the billing or processing of a claim.
Aid Category	A designation within federal or State regulations under which a person may be eligible for public assistance.
Allowed Charge	That part of the reported charge that qualified as a covered benefit, and is eligible for payment under the Virginia Medicaid Program.
Ancillary Services	Services available to patients other than room and board for which charges are customarily made in addition to a routine service charge; e.g., pharmacy, x-ray, lab, and medical supplies.
Appeal	A request for DMAS reconsideration of the denial of a service or eligibility decision for a recipient or of any adverse action affecting a provider's reimbursement.
Attending Physician	The physician rendering the major portion of care or having the primary responsibility for the care of the major condition or diagnosis in an inpatient setting.

BabyCare	Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.
Benefits	Services covered under the Virginia Medicaid Program.
Categorically Needy	Under Medicaid, categorically needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid and who meet the financial eligibility requirements for Aid to Dependent Children (ADC), Supplemental Security Income (SSI), or an optional state supplement.
Claim	A request for payment for services rendered.
Client Medical Management Program	A utilization-control program designed to promote proper medical management of essential health care and enhance service efficiency.
Clinic	A facility for the diagnosis and treatment of outpatients.
Coinsurance	The portion of Medicare- or other insurance-allowed charges for which the patient is responsible.
Copayment	The portion of Medicaid-allowed charges which a recipient is required to pay directly to the provider for certain services or procedures rendered.
Cosmetic Surgery	Cosmetic surgery includes any surgical procedure solely directed at improving appearance.
Covered Services	Services and supplies for which Medicaid will reimburse.
Crossover Claims	Claims for which both Titles XVIII (Medicare) and XIX (Medicaid) are liable for services rendered to a recipient entitled to benefits under both programs.

Current Procedural Terminology	A HCPCS component developed by the American Medical Association. (See the definition of HCPCS.)
Customary Charge	The amount providers usually bill patients for furnishing particular services or supplies.
Date of Service (DOS)	The date or span of days that services were received by a recipient.
Deductible (Medicare)	The amount that the Medicare/Medicaid recipient must pay toward the cost of covered benefits before Medicare payment can be made for additional services. Medicaid pays the Medicare Part B deductible for eligible recipients. Medicare Part A deductible is paid by Medicaid within the Program limits.
Dependent	A spouse or child who is entitled to benefits under the Virginia Medicaid Program.
DESI Drugs	Drug products identified by the federal Food and Drug Administration, in the Drug Efficacy Study Implementation Program, as lacking substantial evidence of effectiveness.
Diagnosis	The identity of a condition, cause, or disease.
Direct Personal Supervision	Supervision rendered at the site of treatment by the responsible participating provider.
Duplicate Claim	A claim which is the same as one previously paid.
Elective Surgery	Surgery which is not medically necessary to restore or materially improve a body function.
Eligible Person	A person eligible for Virginia Medicaid in accordance with the State Plan of the Virginia Medical Assistance Program under Title XIX, who has been certified and enrolled as such by a local social services department.

EPSDT	Early and Periodic Screening, Diagnosis and Treatment. A federally-mandated program for eligible individuals under the age of 21.
Estimated Acquisition Cost (EAC)	Cost for drugs determined by the Virginia Medicaid Program for reimbursement.
Explanation of Medicaid Benefits (EOMB)	A statement mailed once per month to selected recipients to allow them to confirm the services which they received.
Family Planning Services	Any medically-approved means, including diagnosis, treatment, drugs, supplies and devices, and related counseling, which are furnished or prescribed by or under the supervision of a physician for individuals of child-bearing age for purposes of enabling such individuals freely to determine the number or spacing of their children.
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 herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.
Freedom of Choice	The patient's freedom to choose a participating provider of service.
HCPCS	The Health Care Financing Administration Common Procedure Coding System (HCPCS) which includes CPT codes. HCPCS contains services not included in CPT, such as ambulance, audiology, physical therapy, speech pathology, and vision care and such supplies as drugs, durable medical equipment, orthotics, prosthetics, and other medical and surgical supplies.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification: a standardized listing of descriptive terms and identifying codes for reporting diagnoses

	and medical services performed in the inpatient or outpatient facility. These diagnosis and procedure codes are published by the Commission on Professional and Hospital Activities (CPHA).
Inpatient	A patient admitted to a hospital or a nursing facility.
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	A facility or distinct part of another facility certified by the Virginia Department of Health, as meeting the federal certification regulations for an intermediate care facility for the mentally retarded. These facilities must address the total needs of the resident which include physical, intellectual, social, emotional, and habilitation and must provide "active treatment."
Institution for Mental Disease (IMD)	A facility or distinct part of another facility certified by the Division of Licensure and Certification, State Department of Health, as meeting federal certification regulations to provide inpatient hospital psychiatric, medical/surgical, skilled nursing, or intermediate care services to individuals age 65 or older who have a diagnosis of mental disease.
Intensive Care	Constant observation care to critically ill or injured patients in a critical care unit.
Legend Drugs	Drugs which bear the federal caution: "Federal Law Prohibits Dispensing a Drug Without a Prescription."
Maintenance Drug	A drug that is prescribed to treat a medical condition that requires continuous administration for an indefinite period of time.
Maximum Allowable Cost (MAC) (Upper Limits)	The upper limit allowed by the Virginia Medicaid Program for certain drugs.

Medical Necessity	An item or service provided for the diagnosis or treatment of a patient's condition consistent with community standards of medical practice and in accordance with Medicaid policy.
Medically Indigent	Pregnant women, children, and other individuals who meet certain income and/or age requirements and who are eligible for some or all of the covered Medicaid services.
Medically Necessary	Those services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the function of a malformed extremity.
Medically Needy	Individuals whose income and resources exceed those levels for assistance established under a State or federal plan but are insufficient to meet their costs of health and medical services.
National Drug Code (NDC)	A drug code used in pharmacy claims to identify a drug dispensed.
Non-Legend Drugs	Over-the-Counter Drugs.
Nursing Facility (NF)	A nursing facility or a distinct part of another facility licensed by the Division of Licensure and Certification, State Department of Health, as meeting the federal/State licensure and certification regulations for that level of care. A health facility which provides, on a regular basis, services to individuals who do not require the degree of care and treatment which a hospital or specialized care unit is designed to provide, but who require care and services which meet the established written criteria.
Nutritional Supplement	A nutritional supplement refers to enteral or parenteral nutrients given to an individual to make up for deficient nutritional intake. Supplements will be preauthorized through home health only when the supplements are required as the sole nutritional source; may be administered orally or by device; are necessary to treat a medical condition;

and have a physician's order on the treatment plan. Supplements will be preauthorized through EPSDT or the Technology-Assisted or AIDS Waiver when the supplements are required as the primary nutritional source. All supplements must be physician-ordered and not available through WIC, Food Stamps, or other third party insurance.

Outpatient — A patient receiving medical services but not admitted to a hospital.

Over-Utilization — A medically unnecessary use of the Virginia Medicaid Program by any provider and/or recipient.

Participating Provider — A person, organization, or institution with a current valid participation agreement who or which will (1) provide the service, (2) submit the claim, and (3) accept as payment in full the amount paid by the Virginia Medicaid Program.

Personal Comfort Items — Items which do not contribute directly to the treatment of an illness or injury or to the functioning of a malformed body part and are not covered by Medicaid.

Preauthorization — The approval necessary for specified services for a specified recipient by a specified provider before the requested services may be performed and payment made.

Preauthorization Request — Where not otherwise defined in this manual, a preauthorization request shall consist of a written request from the provider (prior to providing the service), identifying the requested service (including the CPT/HCPCS or ADA codes), the patient's name and Medicaid number, and the condition being (to be) treated with documentation supporting the medical necessity, a description of the requested service, the anticipated length of treatment, the prognosis, and the estimated cost of the service.

Procedure Code	A code used to identify a medical service or procedure performed by a provider.
Provider Number	A seven-digit number assigned to identify each provider of services.
Qualified Medicare Beneficiary (QMB)	A low-income Medicare beneficiary eligible for Medicaid coverage of Medicare premiums and of the deductible and coinsurance up to the Medicaid payment limit less any applicable copayments on allowed charges for Medicare-covered services.
Qualified Medicare Beneficiary--Extended (QMB--Extended)	A low-income Medicare beneficiary eligible for Medicaid coverage of Medicare premiums and of the deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services.
Qualified Disabled and Working Individuals (QDWI)	Working disabled individuals who meet certain income limits and are eligible for Medicaid payment of the Medicare Part A premiums only.
Recipient	A person who meets the Virginia Medicaid eligibility requirements and is receiving or has received medical services.
Recipient Eligibility Verification System (REVS)	A toll-free telephone number providing 24-hour-per-day, seven-day-a-week access to current recipient data necessary to verify recipient eligibility for Medicaid services.
Remittance Voucher	A notice sent to providers that advises on the status of claims received. Paid, denied, pended, and adjusted claims are reported on remittance vouchers.
Reported Charge	The total amount submitted on the claim form by a provider of services for reimbursement.

Retroactive Medicaid Eligibility	Medicaid eligibility in which a person was determined to be eligible for a period of time prior to the month in which the application was initiated.
Routine Services	Inpatient routine services in a facility are those services included by the provider in a daily service charge - sometimes referred to as the "room and board" charge. Included in routine services are certain services, supplies, and use of equipment and facilities for which a separate charge is not customarily made.
Spend-Down	A Medicaid recipient eligible for Medicaid for a limited period of time because his or her income exceeds the limits and all other eligibility factors are met. The applicant's incurred medical expenses must equal or exceed the difference between his or her income and the Medicaid income limit.
State Agency	The Department of Medical Assistance Services is the State Agency designated by the General Assembly of Virginia, under the provision of Title XIX of the Social Security Act, to administer Virginia's Medical Assistance Program.
State Plan	A comprehensive written agreement between the state agency administering the Medicaid Program and the Health Care Financing Administration which includes eligibility requirements for recipients and providers and identifies the scope of medical care for which reimbursement is available.
Third Party	Any entity (including other government programs or insurance) which is or may be liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.
Title XIX	That portion of the Social Security Act which authorizes the Medicaid Program.

Title XVIII	That portion of the Social Security Act which authorizes the Medicare Program.