# 2018 Administrative Guide

## Physician, Health Care Professional, Facility and Ancillary

## KanCare Program

## Chapter 19: Glossary/Index of Terms

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UnitedHealthcare® Community Plan

# Welcome

Welcome to the UnitedHealthcare Community Plan care provider manual. This complete and up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Operational policy changes and other electronic tools are ready on our website at UHCprovider.com. Click the following links to access different manuals:

- UnitedHealthcare Administrative Guide for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual-go to UHCCommunityPlan.com, click For Health Care Professionals at the top of the screen. Select the desired state.

Easily find information in the manual using the following steps:

1. Press CTRL+F.
2. Type in the keyword.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF.

If you have any questions about the information or material in this manual or about any of our policies, please call Provider Services.

We greatly appreciate your participation in our program and the care you offer our members.

## Important Information about the use of this manual

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of a conflict between your agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

We amend the manual as policies change.

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# Chapter 19: Glossary/Index of Terms

**Action** – The denial or limited authorization of a requested service, including the type, level or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

**Acute Inpatient Care** – Care provided to persons sufficiently ill or disabled requiring:

1. Constant availability of medical supervision by attending provider or other medical staff
2. Constant availability of licensed nursing personnel
3. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the provider

**Adverse Benefit Determination** – Care provided to persons sufficiently ill or disabled requiring:

1. The denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner, as defined by the State;
5. The failure of United Healthcare to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals;
6. For a resident of a rural area, the denial of a member's request to exercise his/her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network; or
7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

**Ambulatory Care** – Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term "ambulatory care" usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

**Ambulatory Surgical Facility** – A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

**Ancillary Services** – Health services ordered by a provider, including, but not limited to, laboratory services, radiology services, and physical therapy.

**Appeal** – A request to review an Adverse Benefit Determination or an Action, as defined in this chapter.

**Authorized Representative** – Any person or entity acting on behalf of the member or care provider and with the written consent of the member or care provider. A care provider may be an authorized representative of a member.

**Average Length of Stay (ALOS)** – Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.

**Capitation** – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care service.

**Centers for Medicare & Medicaid Services (CMS)** – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

**Children's Health Insurance Plan (CHIP)** – A federal/state funded health insurance program authorized by Title XXI of the SSA and administered by the Kansas Department of Health & Environment/Division of Health Care Finance (KDHE/DHCF.

**Claim** – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.

**Clean Claim** - A claim submitted in **accordance with 42 C.F.R. 447.45,** as amended from time to time, that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

**Coordination of Benefits (COB)** – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

**Complaint** – Any written or oral expression of dissatisfaction by a provider.

**Continuation of Benefits** – The continuation of previously authorized services or course of treatment during the pendency of an appeal or State Fair Hearing concerning an Adverse Benefit Determination terminating, suspending or reducing the member's benefits from KanCare.

**Contracted Services** - Services to be provided by UnitedHealthcare under the terms of our contract with Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF.

**Core Provider Agreement** – A basic contract that Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) holds with medical providers serving Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

**Covered Services** – All Medicaid and CHIP services provided by us in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

**Credentialing** – The verification of applicable licenses, certifications, and experience to assure that provider status is extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by UnitedHealthcare Community Plan.

**Current Procedural Terminology (CPT®) Codes** – American Medical Association (AMA-approved standard coding for billing of procedural services performed.

**Delivery System** – The mechanisms by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, providers' office and home health care.

**Denied Claims Review** – The process for providers to request a review of a denied claim.

**Discharge Planning** – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

**Durable Medical Equipment (DME)** – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a provider.

**Dual Coverage** – When a member is enrolled with two UnitedHealthcare plans at the same time.

**Dual Eligible** – When a member has other insurance that is primary to Medicaid, this could be Medicare or some other primary insurance coverage.

**Early Periodic Screening Diagnosis and Treatment Program (EPSDT)** – A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam. This program is also known as the Kan Be Healthy program.

**Electronic Data Interchange (EDI)** – The electronic exchange of information between two or more organizations.

**Emergency Care** – The provision of medically necessary services required for immediate attention to evaluate or stabilize a medical emergency (see definition below).

**Equivalent Due Process Treatment** – Treating Participating and Non-Participating Providers in an equivalent manner in terms of processing a Grievance, Reconsideration, Appeal or State Fair Hearing. This does not include or apply to reimbursement differences between participating and non-participating care providers.

**Expedited Appeal** – The accelerated review process for appeals when we determine that taking the time for a standard resolution of the appeal could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. See 42 CFR §§ 438.408 and 438.410.

**Expedited Appeal Request** – A request by a member or an Authorized Representative to use an accelerated review process for Appeals when we determine that taking the time for a standard resolution of the appeal could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. See 42 CFR §§ 438.408 and 438.410.

**Expedited State Fair Hearing** – A State Fair Hearing, as defined in this Chapter, and in accordance with the accelerated timeframes and criteria as specified in 42 CFR §§ 431.224 and 431.244 and applicable state laws and regulations.

**Expedited State Fair Hearing Request** – A request by a member, or by an Authorized Representative, for a State Fair Hearing in which final administrative action is made as expeditiously as the member's health condition requires and no later than three business days after the Office of Administrative Hearings (OAH) receives the case information for any appeal of a denial of a service that meets the criteria for expedited resolution as set forth in 42 CFR § 438.410(a), but was not resolved within the timeframe for expedited resolution or was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the member.

**Federally Qualified Health Center (FQHC)** – A facility that is:

1. Receiving grants under section 329, 330, or 340 of the Public Health Services Act; or
2. Receiving such grants based on the recommendation of Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant; or
3. A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638).

**Fee-For-Service (FFS)** – FFS is a term UnitedHealthcare Community Plan uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a member.

**Grievance** – An expression of dissatisfaction about any matter other than an Adverse Benefit Determination, as "Adverse Benefit Determination" is defined in this Chapter, or an Action, as "Action" is defined in this Chapter. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a care provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by us to make a service authorization decision.

**Health Plan Employer Data and Information Set (HEDIS)** – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. 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 cards for managed care organizations.

**Hearing** – An outside hearing conducted by the Office of Administrative Hearings available to all UnitedHealthcare Community Plan members. The member p esents their appeal to an Administrative Law Judge. Members may ask for a State Fair Hearing instead of a UnitedHealthcare Community Plan appeal or at the same time as the UnitedHealthcare Community Plan appeal. Providers must complete the UnitedHealthcare Community Plan appeal process before filing a State Fair Hearing.

**HIPAA** – Health Insurance Portability and Accountability Act. HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs, and mandates the privacy and security of patient information.

**Independent Practice Association (IPA)** – A legal entity, the members of which are independent providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

**Independent Review Organization (IRO)** – A review process by a state-contracted independent third party.

**Integrated Provider Network Database (IPND)** – A database developed to provide verified and integrated provider information for all health plans serving Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) via the Internet and an internal user interface.

**KDHE-DHCF** – The Kansas Department of Health and Environment, Division of Health Care Finance. KDHE-DHCF is the single-state Medicaid Agency for Kansas and the State Agency responsible for the administration and management of the KanCare medical assistance program.

**Medicaid** – The state and federally funded medical program created under Title XIX of the SSA.

**Medical Emergency** – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

**Medical Records** – A confidential document containing written documentation related to the provision of physical, social and mental health services to a member.

**Medically Necessary or Medical Necessity** – As defined in K.A.R. 30-5-58 (ooo)

(1) A health intervention that is otherwise a Covered Service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

(A) **"Authority."** The health intervention is recommended by the treating physician and is determined to be necessary.

(B) **"Purpose."** The health intervention has the purpose of treating a medical condition.

(C) **"Scope."** The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

(D) **"Evidence."** The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph three. For existing interventions, effectiveness shall be determined as provided in paragraph four.

(E) **"Value."** The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean the lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this definition of medical necessity. Interventions that do not meet this definition of medical necessity may be covered at the choice of United. An intervention shall be considered cost effective if the benefits relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

(2) The following definitions shall apply to these terms only as they are used in this subsection;

(A) **"Effective"** means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that out weigh potential harmful effects.

(B) **"Health intervention"** means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

C) **"Health outcomes"** means treatment results that affect health status as measured by the length or quality of a person's life.

**Medicare** – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

A) Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

B) Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

**Member** – A Title XIX or Title XXI Beneficiary who has been certified by the State as eligible to enroll and whose name appears on enrollment information which the State transmits to us every month in accordance with an established notification schedule.

**NCQA** – National Committee for Quality Assurance

**Non-Participating Provider** – A care provider that has not entered into a provider agreement with UnitedHealthcare or subcontractor(s) to serve the members.

**Notice of Action** – A written document issued by United Healthcare to a Provider that provides notice of an Action and meets the format and timing requirements in this manual.

**Notice of Adverse Benefit Determination** – A written document issued by UnitedHealthcare to a member that provides notice of an Adverse Benefit Determination and meets the requirements of 42 CFR § 438.404.

**Notice of Member Appeal Resolution** – A written document issued by United Healthcare to a Member that provides notice of resolution of an Appeal of an Adverse Benefit Determination and meets the format requirements of 42 CFR § 438.408(d)(2) and timing requirements specified in this manual.

**Notice of Provider Appeal Resolution** – A written document issued by UnitedHealthcare to a care provider that provides notice of resolution of an appeal of an action and meets the format and timing requirements specified in this manual.

**Notice of Member Grievance Resolution** – A written document issued by United Healthcare to a Member that provides notice of resolution of a Grievance and meets the format requirements of 42 CFR § 438.408(d)(1) and timing requirements specified in this manual.

**Notice of Provider Grievance Resolution** – A written document issued by UnitedHealthcare to a care provider that provides notice of resolution of a grievance and meets the requirements specified in this manual.

**Notice of Provider Reconsideration Resolution** – A written document issued by United Healthcare to a Provider that provides notice of resolution of a Reconsideration of an Action and meets the format and timing requirements specified in this manual.

**Participating Provider** – A care provider that has a provider agreement with us or our subcontractor(s) to serve members and receives Medicaid or CHIP funding directly or indirectly to order, refer, or render covered services.

**Prior Authorization** – A managed care member's request to receive a service. This is also known as a service authorization.

**Provider Group** – A partnership, association, corporation, or other group of providers.

**Physician Incentive Plan** – Any compensation arrangement between a health plan and a provider or provider group that may directly or indirectly have the effect of reducing or limiting services to members under the terms of the agreement.

**Preventive Care** – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

**Primary Care Provider (PCP)** – A participating provider responsible for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to; pediatricians, family providers, general providers, internists, provider assistants (under the supervision of a provider), or advanced registered nurse practitioners (ARNP), as designated by UnitedHealthcare Community Plan.

**Provider** – An individual or entity that provides, refers, or orders medical services and is legally authorized to do so by the state.

**Quality Improvement Program (QIP)** – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified t hrough the assessment process.

**Reconsideration** – A request by a care provider for us to review an action.

**Remittance Advice (RA)** – Written explanation of processed claims.

**Referral** – The practice of sending a patient to another provider for services or consultation which the referring provider is not prepared or qualified to provide.

**Rural Health Clinic (RHC)** – A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics are entitled to receive enhanced payments for services provided to enrolled members.

**Send** – To deliver by mail or in electronic format as specified in 42 CFR § 431.201.

**Service Authorization** – A managed care member's request to receive a service. This is also known as a prior authorization.

**Service Area** – A geographic area serviced by UnitedHealthcare Community Plan, designated and approved by Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF).

**Specialist** – Any licensed provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

**State** – The State of Kansas, including, but not limited to, any entity or agency of the State.

**State Fair Hearing** – An administrative hearing involving the presentation of evidence and argument before a presiding officer from the Kansas Office of Administrative Hearings concerning an Adverse Benefit Determination or an Action as "Adverse Benefit Determination" and "Action." The presiding officer hears the matter, determines the result, and issues a decision.

**Sub-Contract** – Any written agreement between us and a subcontractor.

**Subcontractor** – An individual or entity with a Subcontract with United Healthcare that relates directly or indirectly to the performance of UnitedHealthcare's obligations under the contract. A Participating Provider is not a Subcontractor by virtue of a provider agreement with United Healthcare.

**Tertiary Care** – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

**Third Party Liability (TPL)** – A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

**Title V** – The portion of the federal SSA that authorizes grants to states for the care of Children with Special Health Care Needs. Title XIX – The portion of the federal SSA that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

**Title XXI** – The portion of the federal SSA that authorizes grants to states for State Children's Health Insurance Program. Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.

**Waiver** – A Home and Community Based waiver of Medicaid provisions for specified groups.

**Women's Health Care Services** – As defined in SAC 284-43-250, Women's Health Care Services is defined to include, but need not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.