



CHAPTER 200—DEFINITIONS
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CHAPTER 200—DEFINITIONS

200 INTRODUCTION

This chapter contains separate lists of acronyms and definitions that are frequently used in the administration of the West Virginia Medicaid Program. The acronyms and definitions are in alphabetical order.

In certain circumstances, more specific definitions will be found in other chapters of this manual. It is suggested that chapters regarding the types of services being utilized also be referenced (e.g., Chapter 501, Aged and Disabled Waiver Services) in addition to the definitions below.

210 – ACRONYMS

- ADA** – American Dental Association
- ADG** – Ambulatory Diagnostic Group
- ADL** – Activities of Daily Living
- ADW** – Home and Community Based Waiver for the Aged and Disabled
- AFDC** – Aid to Families with Dependent Children. Now referred to as TANF.
- ALC** – Alternate Level of Care
- ALS** – Advanced Life Support
- AMA** – American Medical Association
- ANA** – American Nurses Association
- ANSI** – American National Standards Institute
- AWP** – Average Wholesale Price for a drug
- BLS** – Basic Life Support "or" Basic Living Skills
- BMS** – (West Virginia) Bureau for Medical Services
- BoSS** – (West Virginia) Bureau of Senior Services
- CAHPS** – Consumer Assessment of Health Plans Survey
- CC** – Complication or Comorbid Condition Code
- CDC** – Centers for Disease Control and Prevention
- CF** – Conversion Factor
- CFR** – Code of Federal Regulations
- CLIA** – Clinical Laboratory Improvement Act
- CM** – Case Manager
- CMA** – Case Management Agency
- CMS** – Centers for Medicare and Medicaid Services (HCFA prior to July 1, 2001)
- COB** – Coordination of Benefits
- CPT** – Physician's Current Procedural Terminology
- CRNA** – Certified Registered Nurse Anesthetist
- CSHCN** – Children with Special Health Care Needs
- DD** – Developmentally Disabled
- DHHR** – (West Virginia) Department of Health & Human Resources
- DHHS** – (US) Department of Health & Human Services
- DMERC** – Durable Medical Equipment Regional Carrier
- DOB** – Date of Birth
- DOS** – Date of Service
- DRG** – Diagnosis Related Group



DSM – To be determined at a later date - Place Holder
DSS – Decision Support System
DUR – Drug Utilization Review
DX – Diagnosis
EAC – Estimated Acquisition Cost
EDI – Electronic Data Interchange
EDP – Electronic Data Processing
EFT – Electronic Funds Transfer
E/M – Evaluation & Management
EMC – Electronic Media Claims
EMS – Emergency Medical Services
EOB – Explanation of Benefits
EOM – End of Month
EOMB – Explanation of Medical Benefits
EPSDT – Early and Periodic Screening, Diagnosis and Treatment
EQRO – External Quality Review Organization
F&A – Fraud and Abuse
FA – Fiscal Agent
FFP – Federal Financial Participation
FFS – Fee for Service
FFY – Federal Fiscal Year
FI – Fiscal Intermediary
FIFO – First In/First Out
FMAP – Federal Medical Assistance Percentage
FQHC – Federally Qualified Health Center
FPL – Federal Poverty Level
HCBS – Home and Community Based Services
HCFA – (U.S.) Health Care Financing Administration (renamed CMS effective July 1, 2001)
HCPCS – HCFA Common Procedure Coding System
HEDIS – Health Employer Data and Information Set
HHA – Home Health Agency
HHS – (U.S. Department of) Health & Human Services (also DHHS)
HIO – Health Insuring Organization
HIPAA – Health Insurance Portability & Accountability Act of 1996
HM – Homemaker
HMA – Homemaker Agency
HMO – Health Maintenance Organization
HM RN – Homemaker Registered Nurse
ICD – International Classification of Diseases
ICF – Intermediate Care Facility
ICF/MR – Intermediate Care Facility for Persons with Mental Retardation
ID – Identification
IG – Implementation Guide
ISO – International Standards Organization
IT – Information Technology
JCAHO – Joint Commission on Accreditation of Health Care Organization
LOC – Level of Care



LTC – Long Term Care
LTCF – Long Term Care Facility
MAC – Maximum Allowable Cost
MADC – Medical Adult Day Care
MARS – Management Administration Reporting Subsystem
MCO – Managed Care Organization
MDS – Minimum Data Set
MFCU – Medical Fraud Control Unit
MMIS – Medicaid Management Information System
MR/DD – Mentally Retarded/Developmentally Disabled
MSIS – Medicaid Statistical Information System
NABP – National Association of Boards of Pharmacy
NCPDP – National Council of Prescription Drug Programs
NCQA – National Committee for Quality Assurance
NDC – National Drug Code
NF – Nursing Facility
NH – Nursing Home
NPI – National Provider Identifier
NUBC – National Uniform Billing Committee
NUCC – National Uniform Claim Committee
OCR – (U.S.) Office of Civil Rights
OEMS – Office of Emergency Medical Services
OHFLAC – (West Virginia) Office of Health Facility Licensure and Certification
OMCH – (West Virginia) Office of Maternal & Child Health
OSURS – Office of Surveillance and Utilization Review Subsystem
OTC – Over the Counter (Drugs)
PA – Prior Authorization or Prior Approval
PAAS – The Physician Assured Access System
PAHP – Prepaid Ambulatory Health Plan
PASARR – Preadmission Screening and Annual Resident Review
PCCM – Primary Care Case Management
PCP – Primary Care Physician (or Provider or Practitioner)
PHI – Protected Health Information
PIHP – Prepaid Inpatient Health Plan
POC – Plan of Care
POS – Point of Sale
PPS – Prospective Payment System
PRO – Peer Review Organization
PSC – Public Service Commission
QI – Qualified Individual
QIO - Quality Improvement Organization
QMB – Qualified Medicare Beneficiary
QMRP - Qualified Mental Retardation Professional
RA – Remittance Advice
RBRVS – Resource Based Relative Value Scale
RBRVU – Resource Based Relative Value Unit
RHC – Rural Health Clinic



RN – Registered Nurse
RTP – Return to Provider (or Plan)
RUG – Resource Utilization Group
RVS – Relative Value Scale
RVU – Relative Value Unit
SCHIP – State Children’s Health Insurance Plan
SCP – Service Coordination Plan
SFY – State Fiscal Year
SLIMB – Specified Low Income Medicare Beneficiary
SMPMT – Specialized Multi-Patient Medical Transport Provider
SMPV – Specialized Multi-Passenger Van Provider
SNF – Skilled Nursing Facility
SSA – Social Security Administration
SSI – Supplemental Security Income
SSN – Social Security Number
SUR – Surveillance and Utilization Review (SUR)
TANF – Temporary Assistance for Needy Families
TOB – Type of Bill
TPA – Third Party Administrator
TPL – Third Party Liability
UB – Uniform Bill
UB-92 – Uniform Bill Form 92
UPIN – Unique Physician Identification Number "or" Uniform Provider Identification Number
UMWA – United Mine Workers of America – Union of coal miners
UR – Utilization Review
WIC – Women, Infants and Children Program
WVDHHR – West Virginia Department of Health and Human Resources

250 - DEFINITIONS

Abuse of Program – Improper fiscal or medical practices that may result in unnecessary costs to the West Virginia Medicaid Program or the provision of medically unnecessary or inappropriate services.

Active or Curative Care – Any medically necessary care or treatment meant to ameliorate or cure illness or injury.

Activities of Daily Living (ADL) – Activities that a person ordinarily performs during the ordinary course of a day, such as mobility, personal hygiene, bathing, dressing, sleeping, eating, and skills required for community living. A person’s ability to perform these activities is indicative of his or her physical ability to function independently.

Activities of Daily Living Rating Scale – A numerical score used to determine the level of care needs of a beneficiary in performing activities of daily living.

Acute Care – Services available to all Medicaid eligible beneficiaries including, but not limited to, services such as pharmacy, X-ray, laboratory, physician visits, and other services defined in the Medicaid State Plan and approved by the Centers for Medicare and Medicaid Services (CMS).



Advance Directive (Health Care) – Written ahead of time, a health care advance directive is a written document that indicates how an individual wants medical decisions made if he or she loses the ability to make decisions for himself or herself. A health care advance directive may include a Living Will and a Durable Power of Attorney for health care.

Advanced Life Support (ALS) – A sophisticated level of out-of-hospital emergency medical care provided to patients being transported by an ambulance to a hospital.

ALS service is appropriate when the patient manifests symptoms that the absence of immediate medical attention could result in serious harm to the patient.

ALS services include administration of intravenous fluids and the administration of medications by intravenous, endotracheal, intramuscular, subcutaneous, sublingual, inhalation or oral routes, and insertion of endotracheal tube or other advanced airway adjunct device. (Also reference Chapter 524, Transportation Services.)

Aged/Disabled Home and Community-Based Services Waiver (ADW) - West Virginia's home and community-based services waiver program for aged and disabled individuals, administered by the Bureau for Medical Services of the Department of Health and Human Resources in collaboration with the Bureau of Senior Services pursuant to a Medicaid waiver option approved by the Center for Medicare and Medicaid Services (CMS). The Aged/Disabled Waiver Program is a long-term care alternative, which enables individuals to remain at or return home rather than receiving nursing facility (NF) care. The Aged/Disabled Waiver Program provides eligible individuals with a range of services comparable to those services provided in a nursing facility. The Aged/Disabled Waiver Program provides services in homes and local communities instead of a nursing facility. The Aged/Disabled Waiver Program includes case management, homemaker, and adult day care services.

Air Ambulance – An aircraft used for air ambulance operations.

Air Ambulance Transportation – Transport of a patient whose medical condition requires transportation by air ambulance as certified by a physician.

Allied Health Professional – An individual trained to perform services in the care of patients other than a physician or registered nurse; includes a variety of therapy technicians (e.g., pulmonary, radiology technicians, physical therapists, etc.).

Allowable Charge – The maximum amount that West Virginia Medicaid will pay for a covered service.

Ambulance – A vehicle designed, equipped, and appropriately staffed to transport patients to the nearest medical facility that can provide the needed medical care. As classified in West Virginia Health Legislative Rules §64 CSR 48 and §64 CSR 29:

- Class B – Basic Life Support
- Class C – Advanced Life Support
- Class D – Critical Care Transport
- Class E – Aeromedical (Fixed and Rotary Wing)
- Class F – Specialized Multi-Patient Medical Transport Vehicle

Ambulatory Patient – An individual who can move from place to place and exit a building without any means of assistance.



Ambulatory Surgical Center (ASC) – A licensed health care setting that provides outpatient surgery not requiring a stay over 24 hours.

American Dental Association (ADA) – A professional organization for dentists whose mission is commitment to the public's oral health, ethics, science, and professional advancement and leading a unified profession through initiatives in advocacy, education, research, and the development of standards. The ADA maintains a hardcopy dental claim form and the associated claim submission specifications, and also maintains the Current Dental Terminology (CDT) medical code set. The ADA and the Dental Content Committee (DeCC), which it hosts, have formal consultative roles under HIPAA.

American Medical Association (AMA) – A professional organization for physicians whose mission is the development and promotion of standards in medical practice, research, and education; strong advocacy agenda on behalf of patients and physicians; and the commitment to providing timely information on matters important to the health of America. The AMA is the secretariat of the NUCC, which has a formal consultative role under HIPAA. The AMA also maintains the Current Procedural Terminology (CPT) medical code set.

Appropriate Medical Facility – A medical facility is any hospital, medical clinic, physician's office, or other similar facility, licensed or certified by the appropriate State agency, at which medical care and treatment is available. An appropriate medical facility is one whose personnel and equipment are approved to provide medically necessary services to Medicaid patients either on an outpatient or inpatient basis.

Assessment – Use of clinical, functional, demographic, and other information to determine a person's physical, mental, and personal care needs and the most appropriate setting in which to meet those needs and develop a plan of care.

Attending Physician – Physician providing the major portion of care or having primary responsibility for care of the beneficiary.

Authorization of Payment – The transmittal of written notification by the WV Department of Health and Human Resources indicating that an individual has met the financial and medical requirements for Medicaid reimbursement.

Authorized Representative – An individual who has been authorized under West Virginia State law to authorize the termination of medical care or to elect or revoke the election of hospice on behalf of a terminally ill individual who is mentally or physically incapacitated.

Balance Bill – Charges made to the patient for the difference charged for a service and the amount paid by a health insurance plan or other third party. A limit may be imposed on the amount that a provider may balance bill the patient.

Basic Life Support (BLS) – A basic level of out-of-hospital and interfacility emergency medical services provided when a patient requires BLS services or continual medical supervision in those instances when services are determined to be medically necessary in an emergency transport. An emergency transport is one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy
- Impairment to bodily functions



- Serious dysfunction to any bodily organ or part.

Bed Confined – Individuals who are unable to tolerate any activity out of bed. In order to be considered “bed confined,” all of the following criteria must be met:

- The beneficiary is unable to get up from bed without assistance
- The beneficiary is unable to ambulate
- The beneficiary is unable to set in a chair or wheelchair.

Benefits – Services, procedures, and items covered by the West Virginia Medicaid Program or other third party health insurers.

Beneficiary (aka enrollee, client, or recipient) – An individual who is eligible to receive or is receiving benefits from Medicaid.

Board and Care Home – A type of group living arrangement designed to meet the needs of people who cannot live on their own and need help with chore services, homemaking, and other personal care needs.

Board Certified – Formal recognition to a physician that has special training in a certain area of medicine and has passed an advanced examination in that area of medicine. Both primary care doctors and specialists may be board certified.

Breast and Cervical Cancer Early Detection Program – On October 24, 2000, the Breast and Cervical Cancer Prevention and Treatment Act of 2000 ([Public Law 106-354](#)) was signed into law. This Act, which has an effective date of October 1, 2000, gives states the option to provide medical assistance through Medicaid to eligible women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and found to have breast or cervical cancer, including pre-cancerous conditions.

Bureau for Medical Services (BMS and sometimes referred to as “Bureau”) – The single state agency within the West Virginia Department of Health and Human Resources (DHHR) that administers the Medicaid Program mandated under Chapter 9 of the West Virginia Code and Title XIX of the Social Security Act.

Bureau of Senior Services (BoSS) – The Bureau for Medical Services contracts with the Bureau of Senior Services for the day-to-day operation of the Aged and Disabled Home and Community Based Waiver Services program.

Capitation Payment – A payment made periodically to a contractor on behalf of each person enrolled under a contract for the provision of medical services. The payment is made regardless of whether or not the particular person receives services during the period covered by the payment.

Care Management Fee – A per-member, monthly payment to a provider that covers coordination of a member’s health care, such as appropriate referral to consultants, specialists, ancillary provider and services. Care management is intended to ensure continuity of services and accessibility to overcome fragmented services and the misutilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient’s needs over time.



Case Management – A method of coordinating, linking, advocating, and monitoring services for clients to reach goals developed by the beneficiary and the case management agency, other providers, family members, guardians, or legal representatives. Effective case management promotes access to care, containment of escalating costs, enhancement of quality products and services, identification or creation of viable alternative care plans, and patient awareness regarding self-determination and empowerment.

Case Management Agency (CMA) – A privately operated profit or nonprofit organization/agency licensed to do business in West Virginia, having a provider agreement with BMS and enrolled as a provider of case management services.

Case Manager (CM) – Person who arranges for beneficiaries to obtain medically necessary and appropriate services in a coordinated, cost-effective manner.

Case Mix Index – A numerical indicator of the medical needs of the patients a provider treats. The higher the index, the greater the need and cost of caring for the patients.

Categorically Needy – Low income aged, blind, or disabled individuals, low income women and their children, and certain other persons who are *[required by Federal law to be covered by a State's Medicaid Program]* eligible for Medicaid services and meet financial eligibility requirements.

Certification (Laboratory) – Approval of a laboratory facility to receive reimbursement from the Medicaid Program for specific clinical laboratory examination. Such approval is a condition of participation and is granted by the regulating agency (West Virginia Department of Health, Office of Laboratory Services) when a laboratory facility is in compliance with Medicaid regulations.

Certification (Radiology) – Approval of an independent radiology facility to receive reimbursement from the Medicaid Program for specific clinical radiological examination. Such approval is a condition of participation and is granted by the regulating agency (West Virginia Department of Health, Office of Environmental Health Services) when a radiology facility is in compliance with Medicaid regulations.

Certified Medicaid Provider – All transportation entities which have a current Medicaid Provider Number, including aeromedical and ground transport services, which receive reimbursement from the Bureau for Medical Services.

Certified Registered Nurse Anesthetist (CRNA) – A registered nurse who is trained and licensed to administer anesthesia.

CHAMPUS – The Civilian Health and Medical Program of Uniformed Services provides health insurance for active and retired military personnel and their dependents.

Children with Special Health Care Needs (CSHCN) – formerly Handicapped Children's Program - A program for remedial services to medically needy and Medicaid children age 0 to 21 years which is administered by the Department of Human Services under Title V of the Social Security Act.

Claim – An invoice for the health services provided to a patient.

Claimant – A person who requests a hearing under the West Virginia Department of Health and Human Resources Fair Hearing process.



Class I Laboratory – A clinical laboratory independent of a Medicare-approved hospital that is certified for participation in Medicare as an independent laboratory.

Class II Laboratory – A clinical laboratory maintained by one or more physicians for performing diagnostic tests for their own patients provided:

- The laboratory is not held out to other physicians as available to perform diagnostic tests
- The laboratory does not accept more than 100 specimens on referral from other physicians in any one year in any of the following five categories:
 - Microbiology and Serology
 - Clinical Chemistry
 - Immunohematology
 - Hematology
 - Pathology
 - Radiobiology.

Client (aka beneficiary, recipient, or enrollee) – An individual who is eligible to receive or is receiving benefits from Medicaid.

Client Grievance Procedure – The process by which clients are afforded an opportunity to express dissatisfaction with services provided by the Medicaid Program.

Clinic – A legal entity licensed to provide medical services. Group practices and similar arrangement with Medicaid payment to individual members are not considered clinics.

Clinical Laboratory – A facility for the microbiological, cytological, chemical, hematological, radiobiology, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, of treatment of any disease or assessment of a medical condition.

Clinic Services – Federally defined as those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided to outpatients under the direction of the physician. These services must be furnished by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients. Clinic Services must be provided at the clinic, the only exception being services provided to the homeless. (Also refer to Chapter 502, Behavioral Health Clinic Services.)

CMS 64 – A statement of expenditures for the Medicaid program that the Bureau for Medical Services must submit to CMS 30 days after the end of each quarter. The report is an accounting statement of actual Medicaid expenditures for which West Virginia is entitled to receive Federal funding under for the quarter.

CMS 416 – The annual Early and Periodic Screening, Diagnosis and Treatment (EPSDT) report that the Bureau for Medical Services must provide to CMS. The information is used to assess the effectiveness of State EPSDT programs in providing child health screening services.

CMS 1500 — Claim form to bill for most outpatient services that West Virginia Medicaid covers. Formerly HCFA-1500.

Cognitive Impairment – A breakdown in a person's mental state that may affect their moods, fears, anxieties, and ability to think clearly.



Coinsurance. - The portion of the allowed amount payable for a service that is paid by the patient.

Common Carrier – Such services as public railways, buses, cabs, airlines, and other public transportation may be reimbursed at rates approved by the West Virginia Public Service Commission (PSC) or other applicable State or Federal regulatory agency. Transport via common carrier must be preauthorized by the appropriate county Department of Health & Human Resources (DHHR) staff and reimbursed through local DHHR offices.

Communication System – A provider agency for a Medicaid home and community based waiver program having an emergency call down system that is available 24 hours a day, 7 days a week for both the client and any other provider agency to contact in case of an emergency.

Comprehensive Primary Health Care Services – The ongoing responsibility of directly providing preventive and primary health care (including diagnosis and/or treatment and health education) to an enrollee and, as necessary, referring the enrollee to another provider for diagnosis and/or treatment.

Comprehensive Risk Contract – A risk contract that covers comprehensive services, to include, inpatient hospital services and any of the following services, or any three or more of the following services:

- Outpatient hospital services
- Rural health clinic services
- FQHC services
- Other laboratory and x-ray services
- Nursing facility services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
- Family planning services
- Physician services
- Home health services
- Prescribed drugs
- Other services.

Consultation – Referral to a provider for professional advice or services.

Consumer Directed Case Management – Aged and Disabled Waiver program service that gives a client the ability to direct his/her own case management activities personally or through a representative, without reimbursement.

Contractor – An entity that performs specific tasks for the Department under contractual arrangements.

Coordination – Bringing together relevant parties to plan, arrange, implement, and monitor service provisions to beneficiaries.

Co-Payment – A cost sharing amount which is the liability of the beneficiary for the medical services received.

Cost-Based Payment Method – A system of payment for health care whereby reimbursement is based on a percentage of cost.



Cost-Based Reimbursement – A method of payment for health care whereby reimbursement is based on the reasonable and allowable cost a provider incurs in rendering patient care.

Cost Outlier – A patient whose medical care costs extraordinarily more than the care provided to a typical patient with similar medical problems.

Covered Services – Services and supplies for which Medicaid reimbursement is available.

Covered Surgical Procedure – Those surgical and other medical procedures which may safely be performed in the ambulatory surgical center setting and which the ASC is authorized by Federal and State law and regulation to perform.

Crossover Claims – Claims for which Medicare and Medicaid may be responsible for payment for services provided to a client eligible for benefits under both programs.

Current Procedural Terminology (CPT) – A clinical coding system developed and maintained by the American Medical Association and mandated by the Centers for Medicare and Medicaid Services for use in billing Medicare and Medicaid for physician services.

Date of Service – Actual date or number of days that services were received by a client during a month.

Deductible – The amount that an individual must pay before health insurance is liable for some portion of the amount a provider bills for a service. The deductible is ordinarily a flat amount for a year.

Department – The term often used to refer to the West Virginia Department of Health and Human Resources.

Department of Health and Human Services (DHHS) – The organizational unit of the federal government responsible for administration of the provisions of the Social Security Act as amended.

Diagnosis (DX) – Identification of a condition or disease.

Diagnosis Related Group (DRG) – A classification system that groups hospital inpatients according to their diagnoses, surgical procedures, age, and other criteria.

Direct Care Provider – Individual with a special relationship to the client who under normal circumstances would be considered as an informal support.

Dispensing Ophthalmologist – An Ophthalmologist who, in addition to performing the professional services, also dispenses eye appliances.

Disproportionate Share Hospitals – Hospitals that provide care to a large number of Medicare, Medicaid, and low-income patients. Medicaid makes additional payments to these hospitals for the cost of these patients. The Bureau for Medical Services determines whether a hospital meets the criteria to be considered a “disproportionate share hospital” and calculates the additional payment, subject to Federal minimum standards.

Documentation – Process of recording all observations and events in writing and maintaining records or files and reporting information to entities having a right and need to know.

Drug Rebate – Created by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a



national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by CMS' Center for Medicaid and State Operations (CMSO). This law was amended by the Veterans Health Care Act of 1992 which also requires a drug manufacturer to enter into discount pricing agreements with the Department of Veterans Affairs and with covered entities funded by the Public Health Service in order to have its drugs covered by Medicaid.

Drug Utilization Review (DUR) – Drug Utilization Review in the Medicaid program consists of the monitoring of: 1) clinically appropriate prescribing of outpatient drugs, 2) clinically appropriate dispensing of outpatient drugs, 3) drug usage review, evaluation, and intervention, and 4) medical quality assurance.

Dual Eligible – Medicaid beneficiaries who are also eligible for health benefits under Medicare or other public-sponsored health programs.

Durable Medical Equipment – Items, articles, or devices that are prescribed by a physician, primarily and customarily used to serve a medical purpose; generally not useful to a person in the absence of disease, illness, or injury; capable of withstanding repeated use; are durable and nonexpendable (e.g., hospital bed, wheelchair, walker and suction equipment).

Durable Medical Equipment Regional Carrier (DMERC) – A private company that contracts with Medicare to pay claims for durable medical equipment.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program – A comprehensive and preventative child health program for Medicaid eligible individuals under the age of 21. EPSDT includes periodic screening, vision, dental, and hearing services. Periodic schedules for screening, vision, and hearing services must be provided at intervals that meet reasonable standards of medical practice.

Economic Status – Information about a person's income and other related financial resources used to determine Medicaid eligibility.

Electronic Media Claims (EMC) – Claims that are submitted by tape or other electronic forms of communication in lieu of paper claims.

Eligible Hospital – A hospital certified as a provider of hospital services by the Office of Health Facility Licensure and Certification (OHFLAC), the provisions of Title XVII of the Social Security Act, or certified as an out-of-state provider by the Bureau for Medical Services.

Eligible Medicaid Patient – An individual with a valid identification card receiving financial and/or medical assistance from DHHR and children in foster care under Department supervision.

Eligible Person – A person eligible for West Virginia Medicaid according to Title XIX regulations and who has been determined financially eligible by the local office of the Department of Health and Human Resources.

Emergency Medical Services (EMS) – All services which are set forth in West Virginia Code §16-4-C, "The Emergency Medical Services Act of 1996" and those services included in and made part of the emergency medical services plan of the Department of Health and Human Resources including, but not limited to, responding to the medical needs of an individual to prevent the loss of life or aggravation of illness or injury. EMS Rules §64 CSR 48.



Emergency Medical Services Agency – Any authority, person, corporation, partnership, or other entity, public or private, which is licensed by the Office of Emergency Medical Services to provide emergency medical services in West Virginia.

Emergency Medical Services (Ambulance) Certification – The Office of Emergency Medical Services (OEMS) is the certifying agency for emergency medical services (EMS) agencies and has authority over patient transportation through its licensure process. The Bureau for Medical Services of the Department of Health and Human Resources (Medicaid) has the authority to enroll licensed providers for submission of claims for reimbursement.

Emergency Medical Services (Air Ambulance) Provider – Any authority, person, corporation, partnership, or other entity, public or private, which owns or operates a licensed emergency medical services agency providing emergency medical service in this state. Certification of eligibility is issued by the Department of Health and Human Resources and the Office of Emergency Medical Services for the purpose of providing medical treatment and transportation services to Medicaid patients in the State of West Virginia. WV Code §16-4-C; EMS Rules §64 CSR 48.

Emergency Medical Services Provider – Any authority, person, corporation partnership, or other entity, public or private, which owns or operates a licensed emergency medical services agency providing emergency medical service in this state. Certification of eligibility is issued by the Department of Health and Human Resources and the Office of Emergency Medical Services for the purpose of providing medical treatment and transportation services to Medicaid patients in the State of West Virginia. WV Code §16-4-C; EMS Rules §64 CSR 48.

Emergency Medical Services Vehicle (EMS vehicle) – Emergency Medical Services (EMS) transportation vehicles including ambulances, air ambulances and non-medical transportation vehicle as described within EMS Rules §64 CSR 48.

Emergency Medical Technician – Basic (EMT-B) – An individual certified by the Office of Emergency Medical Services (OEMS) to render emergency medical services as defined in the scope of practice and authorized pursuant to West Virginia State Code §16-4C and West Virginia Health Legislative Rules §64 CSR 48.

Emergency Medical Technician – Paramedic (EMT-P) – An individual certified by the Office of Emergency Medical Services (OEMS) to render emergency medical services as defined in the scope of practice and authorized pursuant to West Virginia State Code §16-4C and West Virginia Health Legislative Rules §64 CSR 48.

Emergency Transport – Transport of a patient with a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the beneficiary's health in serious jeopardy
- Impairment to bodily functions
- Serious dysfunction to any bodily organ or part.

Enrollee (aka beneficiary, or client) – An individual who is eligible to receive or is receiving benefits from Medicaid.

Evaluation – An initial and ongoing process to determine service requirements and the effectiveness of plans of care.



Explanation of Benefits (EOB) – A statement mailed once per month to selected clients to allow them to confirm the services they received.

External Quality Review Organization (EQRO) – A private entity that systematically reviews the quality of care provided to Medicaid patients often through medical record reviews.

Federal Financial Participation (FFP) – The proportion of West Virginia Medicaid payments that is the Federal Government's financial responsibility.

Federally Qualified Health Center (FQHC) – An entity that has entered into an agreement with the Centers for Medicare and Medicaid Services to meet Medicare program requirements under 42 CFR 405.2434, and:

- Is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or is receiving funding from such a grant under a contract with the beneficiary of such a grant and meets the requirements to receive a grant under section 329, 330, or 340 of the Public Health Service Act
- Based on the recommendation of the Public Health Service, is determined by Centers for Medicare and Medicaid Services to meet the requirements for receiving such a grant
- Was treated by Centers for Medicare and Medicaid Services, for purposes of part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990

OR

Is an outpatient health program or facility operated by a tribe or tribal organizations under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.

Federally Qualified HMO – A Health Maintenance Organization (HMO) that the Centers for Medicare and Medicaid Services has determined is a qualified HMO under Section 1310(d) of the Public Health Service Act.

Federal Medical Assistance Percentage (FMAP) – The percentage of a State's Medicaid payments that is the financial responsibility of the Federal government.

Fee Schedules – A list of fees or rates for specific inpatient or outpatient services, identified by Diagnosis Related Groups (DRG), Resource-Based Relative Value System (RBRVS), Healthcare Common Procedural Coding System (HCPCS) code, or other coding systems.

Financial Eligibility – The determination of whether the level of a person's income, assets, and categorical standards established by the Department of Health and Human Resources qualifies the applicant for public assistance or Medicaid benefits.

Fixed Winged Aircraft – The fixed wing air ambulance (airplane) services are deemed appropriate when the beneficiary's medical condition is such that transport by ground ambulance is not appropriate. Transport by fixed wing may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. The fixed wing aircraft shall be designed, constructed, or modified; equipped, maintained, appropriately staffed, and operated for the transportation of patients as provided and classified in West Virginia Health Legislative Rules §64 CSR 48.



Fraud – An intentional deception or misrepresentation made by a person or organization with knowledge that the deception could result in an unauthorized benefit to himself or some other individual. It includes any act that is defined as deliberate and intentional under applicable Federal or State laws.

Freedom of Choice – The guaranteed right of a beneficiary to select a provider of their choice.

Full Time Equivalent (FTE) – Forty hours of service per week delivered by one or more individual providers.

Generic Drugs – A generic drug is identical, or bioequivalent to a brand name drug in dosage form, safety, strength, route of administration, quality, performance, characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the branded price.

Goals – Statement of outcome with specific tasks and objectives to achieve those outcomes. Goals are set to ensure that effective services are being provided to the client.

Grievance – The process by which clients are afforded an opportunity to express dissatisfaction with services received by a provider.

Group Practice – A group of persons licensed to practice medicine in the State, who as their principal professional activity, and as a group responsibility, engage or undertake to engage in the coordinated practice of their professions, primarily in one or more group practice facilities, and who in the connection share common overhead expenses if and to the extent such expenses are paid by members of the group, medical and other records, and substantial portions of the equipment and the professional, technical, and administrative staffs.

Health Care Financing Administration (HCFA) – Formerly the Federal Agency that administered the Medicare and the Medicaid Programs. HCFA has been replaced with the Centers for Medicare and Medicaid Service (CMS) effective July 1, 2001.

Health Care Financing Administration Common Procedure Coding System. (HCPCS) – A three level coding system used to report medical services, procedures, and items. Level 1 consists of codes from the Current Procedure Terminology, fourth edition (CPT-4), which are used to report physician services. Level II codes apply nationally to non-physician services and supplies and equipment. Level III codes are for services, procedures, or supplies for which no national codes exist.

Health Care Professional – A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health Check (EPSDT) Program – The program, operated for the Medicaid Program through the Office of Maternal and Child Health, to ensure the Medicaid eligible children, ages 0 through 20 years, receive a comprehensive range of preventive and primary health care services. Health Check has an outreach component with regional staff who provide technical assistance, computer generated schedules, follow-up for missed appointments, assistance with



transportation for eligible children, and other functions which support preventive and primary health care services.

Health Employer Data and Information Set (HEDIS) – A set of standard performance measures that provides information about the quality of care that a health plan provides. HEDIS measures include quality of care, access, cost, and other measures to compare managed care plans.

Health Insurance Portability and Accountability Act (HIPAA) – A Federal law that allows persons to qualify for comparable health insurance when they change jobs. This law also establishes standards for the electronic exchange and use of health care data to safeguard the privacy and security of an individual's personal health information.

Health Insuring Organization (HIO) – A county-operated entity that, in exchange for capitation payments, covers services for beneficiaries:

- Through payments to, or arrangements with, providers
- Under a comprehensive risk contract with the State
- Meets the following criteria
 - First became operational prior to January 1, 1986
 - Is described in Section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by Section 4734 of the Omnibus Budget Reconciliation Act of 1990).

Home – The beneficiary's place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

Home and Community Based Waiver for the Aged and Disabled (ADW) – Also known as the DHHR Medicaid Waiver Program for the Aged and Disabled, or simply the ADW Program.

Home Health Aides – Persons specially trained to assist sick, disabled, infirm, or frail persons at home when no family member is fully able to assume this responsibility. These aides are supervised by health professionals, and provided as part of a continuing medical care plan.

Home Health Care – Health care provided in the home to clients as an alternative to institutional care. The most common types of home care are skilled nursing services, speech, physical, and occupational therapy.

Homemaker – A care provider who provides in-home services to an eligible beneficiary of the program.

Homemaker Agency (HMA) – The agency responsible for assuring appropriate training of the homemaker, placing the homemaker in a client's home, and monitoring the client care and homemaker performance.

Homemaker Services – Direct care and support services that are necessary in order to enable an individual/client to remain at home rather than enter a nursing facility, or to enable an individual to return home from a nursing facility. Homemaker services in the ADW Program include assistance with personal hygiene, nutritional support, and environment maintenance.



Hospice – A public agency or private organization or subdivision of either of these that is primarily engaged in providing care to terminally ill individuals. A Hospice must meet the conditions specified in Title 42 of the Code of Federal Regulations (CFR) 418.50 to 418.100.

Individual – A person applying for Medicaid, or anyone referred to in a general way to connote the norm in health care delivery or standards.

Informal – Volunteer provider or family member who is not reimbursed for services.

Inpatient – A patient who has been admitted to a hospital or long-term care facility on the recommendation of a physician and is receiving room, board, and professional services in the institution on a continuous, 24-hour-a-day basis.

Intermediate Care Facility (ICF) – A long-term care institution which meets licensing requirements according to State law, and/or is certified by Office of Health Facility Licensure and Certification (OHFLAC) to provide, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services which can be made available only through institutional facilities.

Intermediate Care Facility for the Mentally Retarded (ICF/MR) – A facility certified by the West Virginia Department of Health and Human Resource's Office of Health Facility Licensure and Certification as meeting federal certification regulations as an Intermediate Care Facility for the Mentally Retarded or those with related conditions. These facilities must address the total needs of the resident including physical, intellectual, social, emotional, habilitation and provide "active treatment."

Intake – The process of interviewing a person to gather the necessary information to aid the client in obtaining the services available through the Aged and Disabled Waiver Program or a nursing facility.

Level of Care (LOC) – The number of homemaker hours of service for which a client is eligible, as determined by set criteria using the PAS-2000

Level of Care Requirements – The Bureau's requirement for payment on behalf of a beneficiary if that beneficiary were residing in a Bureau enrolled medical assistance institution.

Locality – The area surrounding the institution from which individuals are expected to come for medical services.

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a comprehensive risk contract under the following:

A Federally qualified HMO that meets the advance directive requirements of subpart I of part 489 of the Federal Register definition of a Federally Qualified HMO.

Any public or private entity that meets the advance directive requirements and is determined to also meet the following conditions:

Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area serviced by the entity.

Meets the solvency standards of Section 438.1176.



Mandatory Medicaid Benefits – Specific types of basic health services that a State must provide to categorically needy beneficiaries in order to have a valid Medicaid program. Some of the basic services are hospital inpatient and outpatient services, physician services, nursing facility services for individuals aged 21 years or older, home health care for persons eligible for nursing facility services, family planning services and supplies, laboratory and x-ray services, and pediatric and family nurse practitioner services.

Maximum Allowable Cost (for prescription drugs) (MAC) – Upper limits which may be established by the Federal government or the Federal Department of Health and Human Services.

Medicaid (aka Title XIX, Title 19) – A joint Federal and State program that pays for much or all of the health care services provided to eligible persons with low incomes and limited resources. Medicaid Programs are administered by the States with Federal guidelines and vary from state to state.

Medicaid State Plan – A comprehensive written agreement between the Bureau for Medical Services (BMS) and the Centers for Medicare & Medicaid Services (CMS) that includes eligibility requirements for clients and identifies the scope of medical services for which Federal reimbursement is made.

Medical Adult Day Care (MADC) – Is designed to be an alternative to institutional services, by providing participants with routine health and maintenance care combined with daily structured and supportive activities in a congregate daytime setting. MADCs are responsible for providing routine health and maintenance care combined with daily structured and supportive activities in a congregate daytime setting.

Medical Eligibility – The decision by the Bureau for Medical Services or its agent that the health care status and treatment requirements as prescribed by a medical practitioner substantiates the level of care and criteria for Medicaid benefits.

Medical Identification Card – An identification card issued monthly to each patient or family unit designed to give the provider of medical services the beneficiary identification information for billing purpose.

Medicaid Management Information System (MMIS) – Electronic information system designed and mandated by the Federal government to administer the West Virginia Medicaid Program in a manner that is consistent with all Federal requirements.

Medicaid Statistical Information System (MSIS) – An electronic file that a State submits quarterly to CMS providing specified data elements for the persons covered by Medicaid and paid claims for medical services. The purpose of MSIS is to collect, manage, and disseminate information about beneficiaries and the utilization of and payments for services.

Medical Patient – Any individual who is incapacitated due to injury, illness, disease or mental condition and requires continual medical supervision during transportation to or from an appropriate medical facility or any person who is a beneficiary of the services provided by emergency medical services.

Medical/Social Worker/Social Services – A service provided by a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and is licensed as a Social Worker.



Medically Appropriate – An effective service that can be provided, taking into consideration the particular circumstances of the beneficiary and the relative cost of any alternative services, which could be used for the same purpose, that is, the most economical service that meets the beneficiary's health needs.

Medically Necessary – Services or supplies that are proper and needed to diagnose or treat a medical condition.

Medically Needy – An individual whose income and resources exceed the levels for assistance established under a State or Federal plan, but whose income and resources are not enough to meet the costs of his/her health and medical services.

Medicare – The 1965 Amendments to the Social Security Act added a new Title (XVIII) Health Insurance for the Aged. Title XVIII, popularly known as Medicare, established a broad program of health insurance for the elderly and certain disabled individuals which is Federally administered through fiscal agents.

Medicare/Medicaid Patient – An individual eligible for Medicare; i.e., 65 years of age or older and certain disabled individuals also receiving medical or financial assistance from the Department of Human Services.

Member – An individual who is enrolled in a managed care plan.

Mental Status – Intellectual functioning, cognitive abilities and emotional status of the client.

Mobile Nonambulatory Patient – An individual that is able to move from place to place, and self exit a building, with the use of a device such as a walker, crutches, or a wheelchair.

MR/DD Waiver Program – The Waiver Program for Mentally Retarded and Developmentally Disabled persons.

MR/DD Waiver Program Services – Services provided under the MR/DD Waiver Program which include Service Coordination, Extended Physician Services (annual medical evaluation), Day Habilitation including Qualified Mental Retardation Professional (QMRP) services, Prevocational Training, Supported employment, Residential Habilitation, Transportation and Respite Care.

Multiple Patients – Transportation of more than one patient at a time is only reimbursable in an emergency transport and should only be used when no other ambulances are available for transport, i.e., mass casualty incident. If transporting more than one patient, the agency can only bill mileage once. It is not permissible to bill mileage for each patient that is being transported in the same ambulance at the same time. This does not include the following transport services which are designed for transporting multiple passengers at the same time:

- Specialized Multi-Patient Medical Transport (SMPMT)
- Specialized Multi-Passenger Van Provider (SMPV)
- Common Carrier Services.

Neuropsychological Evaluation – Full battery of tests used to develop a diagnosis. The evaluation is the sum of all the testing and diagnostic interview sessions. The components of the neuropsychological evaluation are: patient history; assessment of perceptual motor function; language functions; attention, memory, learning, intellectual process, and level; and emotional, behavioral, and personality functioning. The evaluation must be accomplished by means of



appropriate psychological procedures administered by a qualified neuropsychologist. Appropriate psychological procedures include, but are not limited to, Wechsler Adult Intelligence Scale, the Wide Range Achievement Test, the Wechsler Memory Scale, the Luria Nebraska Neuropsychological Battery, and the Halstead-Reitan Neuropsychological Battery.

Non-Emergency Transport – Non-emergency services may be scheduled or unscheduled trips that do not meet the criteria for emergency regardless of the origin or destination. Trips for hospital discharge, to and from ESRD facilities for dialysis, to and from other outpatient facilities for chemotherapy, radiation therapy, or other diagnostic services are considered non-emergency services.

For non-emergency services the beneficiary must be bed confined at the time of the ambulance service is provided. The term "bed confined" is not synonymous with "bed rest" or "non-ambulatory." Bed confined is one factor to be considered but is not the sole criterion to determine medical necessity.

Bed confined requires all of the following criteria to be met:

- The beneficiary is unable to get up from bed without assistance
- The beneficiary is unable to ambulate
- The beneficiary is unable to sit in a chair or wheelchair.

Nonrisk Contract – A contract under which the contractor –

- Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in Section 447.362
- May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Nursing Facility (NF) – A nursing home or a distinct part of another facility licensed by the West Virginia Department of Health & Human Resources Office of Health Facility Licensure and Certification as meeting Federal and State licensure and certification regulations. A health facility that provides, on a regular basis, services to individuals who do not require the degree of care and treatment that a hospital is designed to provide but who require nursing and/or restorative services.

Nursing Facility Services – Services provided for individuals who need the professional judgment of skilled nursing or rehabilitation personnel and/or medical therapy and sterile techniques on a continuous basis.

Observation – Process in which an individual notes a client's condition, progress, behaviors, and environment.

Office of Emergency Medical Services (OEMS) – The division within the Department of Health and Human Resources responsible for assuring Emergency Medical Services (EMS) agencies and personnel are in compliance with West Virginia State Code §16-4C and West Virginia Health Legislative Rules §64 CSR 48 and §64 CSR 29 which includes licensure, certification, and annual inspections of EMS vehicles.

Office of Family Support – The Office in the Bureau for Children and Families in the West Virginia Department of Health & Human Resources that determines an individual's financial eligibility for Medicaid and other services.



Office of Health Facility Licensure and Certification (OHFLAC) – The office designated by the West Virginia Department of Health and Human Resources to determine whether facilities comply with Federal and State licensure and State certification standards.

Office of Surveillance and Utilization Review (OSUR) – The office within the West Virginia Department of Health & Human Resources that detects and examines any unusual patterns of payments and unnecessary or inappropriate utilization of care and services covered under the Medicaid Program. Activities of this Office may involve a multi-disciplinary approach in coordination with other Department offices and contractors.

Olmstead Act – In July 1999, the Supreme Court issued the Olmstead v. L. C. decision. The Court's decision in that case clearly challenges Federal, state, and local governments to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective, community-based services. The Olmstead decision interpreted Title II of the Americans with Disabilities Act (ADA) and its implementing regulation, requiring States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

Outpatient – A patient who is evaluated or treated at a hospital emergency department, medical clinic, diagnostic center, or other appropriate medical facility who is not receiving room, board, and professional services on a 24-hour-a-day basis.

Outpatient Hospital Service – Preventive, therapeutic, or palliative items or services furnished by or under the direction of a physician to an outpatient.

Outpatient Medical Benefits – Specific types of services that a State may include in its Medicaid Program and have part of the costs absorbed by the Federal government. Some of the most frequently covered optional services are clinic services; nursing facility services for beneficiaries under age 21, intermediate care facility/mentally retarded services, optometrist services and eyeglasses, prescribed drugs, and dental services.

Over-Utilization – Excessive use of the Medicaid Program by any provider or beneficiary.

Palliative Care – Any treatment which controls pain, manages symptoms, enhances comfort, and improves the quality of life.

Part A – The portion of the Medicare Program that covers hospital inpatient care, inpatient care in skilled nursing facilities, home health care, and hospice care.

Part B – Medicare Supplementary Medical Insurance. The part of the Medicare Program that covers physician services, hospital outpatient care, home health care, durable medical equipment, and certain other outpatient services.

Participating Common Carrier/Individual Volunteer Providers – A provider of non-medical, non-ambulance transportation of Medicaid beneficiaries. Such services may include; public railways, buses, cabs, airlines; or other firms, corporations, and entities who are certified pursuant to the regulations as established by the Public Service Commission and DHHR; and individual volunteers; all as defined herein.

Participating Ground Ambulance Provider – A provider of ground medical transportation services that has been granted certification, as defined herein, by the Office of Emergency Medical Services (OEMS) and Department of Health & Human Resources (DHHR) for the provision of medical transportation of Medicaid patients and who elects to participate in and



seeks reimbursement from DHHR Bureau for Medical Services, pursuant to the regulations herein.

Levels of ground medical transportation includes Advanced Life Support (ALS), Basic Life Support (BLS), Ambulance Medical Transport (AMT), and Specialized Multi-Patient Medical Transport Provider (SMPMT) as defined herein.

Participating Providers – Hospitals, nursing facilities, home health agencies and practitioners who are enrolled in the Medicaid Program to provide covered services to Medicaid beneficiaries.

PAS-2000 – Pre-Admission Screening form; comprehensive medical evaluation used to determine medical eligibility in the ADW Program.

Patient Management Services – Responsibility for management of the assigned enrollee's health care through direct service provision, arrangement by referral and/or approval of PAAS, including medical services and maintenance of a unified medical record.

Patient Transportation – Movement or transfer of a patient from one location to another by an approved and designated ambulance. EMS Rules §64 CSR 48.

Peer Review Organization (PRO) – Federally designed program charged with the responsibility of utilization and quality review of the necessary medical care provided Medicaid and Medicare patients.

Per Diem – A daily rate of reimbursement for services provided in a facility setting on an inpatient basis.

Physical Environment – Condition of the client's home and how well it meets the client's needs.

Physical Health – General physical condition and mental status of an individual and services which will improve or maintain a beneficiary's health.

Physical Therapy – Services prescribed by a physician and provided by or under the direct supervision of a "qualified physical therapist." A qualified physical therapist is a graduate of a program of physical therapy approved by the American Physical Therapy Association and the Council on Medical Education of the American Medical Association and is licensed or registered in the state.

Plan of Care (POC) – An agreement between the client and case management which identifies a client's problem goals and services to be provided by the ADW Program.

Preauthorization (Prior Approval) – Authorized in advance of the service as a condition for payment.

Prepaid Ambulatory Health Plan (PAHP) – An entity that:

- Provides medical service to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates,
- Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees
- Does not have a comprehensive risk contract.



Prepaid Inpatient Health Plan (PIHP) – An entity that:

- Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees
- Does not have a comprehensive risk contract.

Primary Care – The ongoing responsibility of directly providing routine medical care (including diagnosis and/or treatment and health education) to an enrollee and, as necessary, referring the enrollee to another provider for diagnosis and/or treatment.

Primary Care Case Management (PCCM) – A system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to Medicaid beneficiaries.

Primary Care Case Manager (PCCM) – A physician, a physician group practice, or an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

- A physician assistant
- A nurse practitioner
- A certified nurse-midwife.

Primary Care Practitioner or Clinic – A Medicaid participating provider of routine care for health promotion and maintenance. A primary care practitioner may be a practicing general or family physician, pediatrician, internist, gynecologist, general surgeon, certified adult or pediatric nurse practitioner, or physician's assistant.

Prior Authorization (PA) – Prior approval necessary for specified services to be delivered for an eligible client by a specified provider before services can be performed, billed, and payment made. A utilization review method used to control certain services which are limited in amount, duration, or scope.

Prior Authorization for Extended Hours – Request for approval of additional services in excess of the client's approved Level of Care.

Prior Authorization Request – Where not otherwise deemed in this manual, a prior-authorization request shall consist of a written request from the case management agency (prior to arranging for services to be delivered) that identifies the requested services. The client's name, Medicaid number, the condition to be treated, a description of requested treatment, anticipation length of treatment, anticipation cost, and a working prognosis must be included in the request.

Private Vehicle Transportation by Individuals – Individuals are permitted to transport Medicaid patients in private autos. Payments are processed by staff in the West Virginia Department of Health & Human Resources county offices and reimbursements made through the non-medical, non-ambulance Transportation Program.



Procedure Code – A code used to identify a medical service or procedure performed by a provider and billed to Medicaid on the CMS-1500 claim form.

Proficiency Testing – A method of quality control that periodically sends specimens to a laboratory for analysis and comparison with the findings for the original test.

Prospective Payment System (PPS) – A method that pays hospitals and nursing facilities a fixed amount to provide inpatient care to Medicaid beneficiaries. The amount is determined before services are provided. The amount for hospital inpatient care is for the entire stay; for nursing facility care, the amount is for one day of care.

Provider Number – A unique 10-digit number assigned by the Bureau for Medical Services to identify each provider of services and which identifies the service provider on the CMS-1500 claim form. The number is essential for billing purposes.

Psychological Services – The evaluation and therapy services provided by an independently practicing licensed psychologist.

Psychologist Under Supervision for Licensure – An individual who:

- Is an unlicensed psychologist with a documented, completed degree in psychology at the level of a Ph.D., Psy.D., Ed.D., M.A., or M.S.
- Has met the requirements of, and is formally enrolled in, the West Virginia Board of Examiners of Psychologists Supervision Program
- Is working towards licensure
- Is employed by and receives two hours of supervision per 40 hours of employment from a Medicaid enrolled psychologist.

Quality Improvement Project – A program designed to improve quality, which includes collection of baseline measures with development and implementation of appropriate interventions, followed by re-measurement.

Reassessment, Reevaluation – An update and review of the client's case to determine the appropriateness of the individualized Service Coordination Plan and Plan of Care.

Referral – The process of sending a patient from one practitioner to another for health care services. The Physician Assured Access System requires that the designated Primary Care Provider authorize a referral for coverage of specialty services.

Regional Office Review – The Centers for Medicare and Medicaid Services Regional Office must review and approve all Managed Care Organization, Prepaid Inpatient Health Plan (PIHP), and Prepaid Ambulatory Health Plan (PAHP) contracts, including those risk and nonrisk contracts.

Registered Nurse (RN) – A person who is professionally licensed by the State of West Virginia as a Registered Nurse.

Reported Charge – Total amount submitted for reimbursement on a claim form by a provider of services.

Residence – The beneficiary's full-time residence, but does not include a hospital, nursing facility, intermediate care facility or any other residential setting in which nursing services are



already available. Personal care services cannot be provided in a hospital, nursing facility, or Intermediate Care Facility.

Risk Adjustment – The dollar amount that is added to or subtracted from a payment rate because the person’s health status is below or above the average.

Risk Contract – A contract under which the contractor:

- Assumes risk for the cost of the services covered under the contract
- Incurs a gain or loss depending on the cost of furnishing the services covered by the contract.

Resource Based Relative Value Scale (RBRVS) – A list of relative value units (or weights) assigned to different types of physician services. The units indicate the cost of and amount paid for one service compared to the cost of and amount paid for the average services. A weight of 2.20 for a service means that the service is 200 percent as costly as the average services. If the average service cost is \$30, the specific service would cost \$66 = $\$30 \times 2.20$.

Resource Utilization Groups (RUG) – A system that is used to classify nursing home patients in groups based on their medical needs and functional and behavioral characteristics. Information from the Minimum Data Set is used to assign patients to these groups.

Retroactive Medicaid Eligibility – Medicaid eligibility in which a person was determined to be eligible for a period of time prior to the day on which the applicant’s financial eligibility was entered into the Medicaid Management Information System (MMIS) for payment.

Rotary Wing Aircraft – The rotary wing air ambulance (helicopter) services are deemed appropriate when the beneficiary’s medical condition is such that transport by ground ambulance is not appropriate. Transport by fixed wing may be necessary because the beneficiary’s condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. The fixed wing aircraft shall be designed, constructed or modified; equipped, maintained, appropriately staffed, and operated for the transportation of patients as provided and classified in West Virginia Health Legislative Rules §64 CSR 48.

Rural Health Clinic (RHC) – Authorized by Section 1102 of the Social Security Act, September 19, 1978, established a class of providers known as Rural Health Clinics which were to be located in designated medical shortage areas, employing nurse practitioners and/or physician assistants under the supervision by physicians, reimbursed on cost-related basis per patient encountered at a rate determined by Medicare physical intermediaries.

Rural Health Clinic Services – Services furnished by a physician within the scope of practice of his/her profession under state law, and services furnished by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse under the supervision of a physician. Such services may be furnished in the rural health clinic location or away from the clinic by one of the above mentioned practitioners who has an agreement with the clinic that the practitioner will be paid by it for such services.

Service Coordination Plan (SCP) – An agreement between the client and case management agency which identifies client needs, goals, outcomes, and services to be provided by the Aged and Disabled Waiver.



Service Provider – Any individual or agency who coordinates or provides identified program services to individual clients.

Session – The time period used in a psychotherapy service or evaluation service and limited to increments of 20 minutes up to one and one-half hour, depending on the service modality and procedure code.

Single State Agency – The agency designated by the West Virginia Legislature to administer a particular State program. The Bureau for Medical Services is the single state agency that administers the West Virginia Medicaid Program.

Slot Allocation Methodology – A method to equitably distribute waiver allocations.

Specified Low-Income Medicare Beneficiaries (SLIMBs) – Medicare beneficiaries with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level but less than 120 percent of the Federal Poverty Level. The Medicaid Program pays their monthly Medicare Part B premiums.

Specialized Multi-Patient Medical Transport Provider (SMPMT) – A non-emergency transport service provided by an EMS agency licensed to provide this service by the Office of Emergency Medical Services (OEMS). This service is provided to beneficiaries who are ambulatory and/or mobile nonambulatory with a medical history, but have no apparent immediate need for any level of medical services while being transported to and from scheduled medical appointments. Vehicles and staff must comply with the rules and requirements set forth in West Virginia Health Legislative Rule §64 CSR 29.

Specialized Multi-Patient Medical Transport Vehicle – A vehicle owned and operated by a licensed emergency medical services agency used to provide transportation to ambulatory patients with a medical history but who have no apparent immediate need for any level of medical supervision while being transported to and from scheduled medical appointments.

Specialized Multi-Passenger Van Provider (SMPV) – An organization or entity which operates specialized multi-passenger vans equipped to transport ambulatory and/or mobile nonambulatory patients as described in the medical necessity attachment. SMPV vehicles and personnel shall meet the requirements set forth by these regulations. These vehicles and personnel are to provide safe, sanitary, and comfortable transportation to and from scheduled medical appointments and cannot be utilized for the transportation of Advanced Life Support or Basic Life Support medical patients. This category of transportation provider submits claims directly to the Medicaid Program.

Specialized Multi-Passenger Van Provider (SMPV) Certification – Certification of eligibility issued by the West Virginia Department of Health & Human Resources, Bureau for Medical Services, and the Office of Emergency Service or the Public Service Commission and any other federal governing agency or departments of the State of West Virginia to any individual, firm, corporation, association, county, municipality or other legal entity for the purposes of providing non-ambulance transportation services to eligible Medicaid beneficiaries in the State of West Virginia.

Spend Down – The process by which a person whose income is too high to qualify for Medicaid spends the excess amount on health care and subsequently may qualify for Medicaid benefits.



State Agency – The Bureau for Medical Services is the agency under the provision of Title XIX of the Social Security Act to administer the West Virginia Title XIX Medicaid Program.

State-Only Health Programs – Health benefits that the State provides to eligible persons that is funded entirely from State revenues—that is, the Federal government does not share in the cost of the program, as it does for Medicaid.

State Plan – A comprehensive written agreement between the state agency administering the Medicaid Program and the Centers for Medicare and Medicaid Services, which includes client eligibility requirements and identifies the scope of medical care for which reimbursement is available.

Supplemental Security Income (SSI) – A federal program that provides financial assistance to eligible aged, blind, and disabled persons.

Targeted Case Management Services – The services covered by the West Virginia Medicaid Program to provide targeted case management to Medicaid eligible individuals with mental illness, development disabilities, and substance abuse, pursuant to the case management option available to States under Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Terminally Ill – A medical prognosis, by a physician, has determined that an individual's life expectancy is 6 months or less if the illness runs its normal course.

Third Party – Any entity (including other government programs or insurance program) that is or may be liable for payment of all or part of the medical cost for injury, disease, or disability of a client of Medicaid services. Medicaid is always the payer of last resort.

Third Party Liability (TPL) – Financial resources available to the beneficiary to cover costs for medical care. The third party may be private health insurance, Medicare or Medicaid, or retiree health benefits.

Title XIX – The section of the Social Security Act that authorizes the Medicaid Program.

Title XVIII – The section of the Social Security Act that authorizes the Medicare Program.

Unduplicated Recipient/Beneficiary Count – The number of different persons who receive at least one service during a stated time period. Each person is counted once, regardless of the number of services received.

Unit – A standard measure of services provided to an eligible client.

Usual, Reasonable and Customary Charge – Amount providers charge the general public for services or supplies.

Waiver Program for Mentally Retarded and Developmentally Disabled Persons or MR/DD Waiver Program – West Virginia's home and community-based services program for individuals who have mental retardation and or developmental disabilities, administered by the Bureau for Medical Services of the Department of Health and Human Resources in collaboration with the Office of Behavioral Health Services pursuant to a Medicaid waiver option approved by the Center for Medicare and Medicaid Services. The MR/DD Waiver Program is a health care coverage program that reimburses for services to instruct/train, support, and assist individuals who have mental retardation and/or related conditions to achieve the highest level of independence and self-sufficiency possible in their lives. The MR/DD Waiver Program serves individuals who are eligible to receive services in an Intermediate Care Facility for Individuals



with Mental Retardation and Related Conditions (ICF/MR). The MR/DD Waiver Program provides services in homes and local communities instead of ICF/MRs.

West Virginia Department of Health and Human Resources (DHHR) – Cabinet-level department responsible for the administration of health and human services programs in West Virginia.

WVDHHR Title XIX Medicaid Waiver Program for the Aged and Disabled –The Aged and Disabled Home and Community–Based Services Waiver as defined in Chapter 501, Aged & Disabled Waiver Services.

X-Ray Technologist – Operations of equipment is by practitioner or by an x-ray technologist, under his/her direct supervision. An x-ray technologist is defined as an individual licensed under State law to make medical x-rays.