



Florida Medicaid

Definitions Policy

Agency for Health Care Administration

August 2017



1.0 Introduction

This policy contains definitions of commonly used terms that are applicable to all sections of Rule Division 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy or rule.

This policy is intended for use by all providers that render services to Florida Medicaid recipients. This policy must be used in conjunction with Florida Medicaid's general policies and any applicable service-specific and claim reimbursement policies with which providers must comply.

All Florida Medicaid policies are promulgated in Rule Division 59G, F.A.C. Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

2.0 Definitions

2.1 Abuse

As defined in section 409.913, Florida Statutes (F.S.).

2.2 Activities of Daily Living (ADLs)

ADLs include:

- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
- Toileting
- Transferring

2.3 Adjudicate

Make an official decision regarding a claim submitted to AHCA, or its designee, for payment.

2.4 Adult Health Screening

Medical examination furnished to assess the health status of recipients age 21 years and older in order to detect and prevent disease, disability and other adverse health conditions or their progression.

2.5 Agency (AHCA)

The Florida Agency for Health Care Administration.

2.6 Applicant, Provider

Individual, group, or organization that has submitted a written application to become a Florida Medicaid provider to AHCA, or its designee, but has not yet received final action.

2.7 Applicant, Recipient

Individual who has submitted an application for Florida Medicaid to the Florida Department of Children and Families, but has not received a final action, including an individual whose application was submitted through a representative or a person acting on his or her behalf.

2.8 Attending Physician

Doctor of medicine or osteopathy licensed in accordance with Chapter 458 or 459, F.S., and who is identified as having primary responsibility for a recipient's medical care.

2.9 Audit

Examination of records supporting amounts reported in an annual cost report, to determine the accuracy and propriety of the report; or, an analysis of documentation supporting a

provider's Florida Medicaid claims during a period of time, to determine whether payments were accurate.

2.10 Authorization

Approval to deliver Florida Medicaid covered services.

2.11 Authorized Representative

As defined in Title 42, Code of Federal Regulations (CFR), section 435.923.

2.12 Beneficiaries

Persons receiving medical benefits under Medicare.

2.13 Billing Agent

Florida Medicaid-enrolled entity that offers claims submission services to providers.

2.14 Business Records

Documents related to the administrative or commercial activities of a provider.

2.15 Calendar Year

The period of days beginning on January 1 and ending on December 31.

2.16 Cap

See Service Limit.

2.17 Care Plan

See Plan of Care or Plan of Treatment.

2.18 Caregiver

Person(s) attending to the needs of another person, who is physically or mentally impaired, injured, incapacitated, or a child unable to care for him or herself.

2.19 Case Management

A process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a recipient's or an enrollee's health needs using communications and all available resources to promote quality outcomes. Proper care coordination/case management occurs across a continuum of care, addressing the ongoing individual needs of a recipient or an enrollee rather than being restricted to a single practice setting.

2.20 Case Manager

Individual who furnishes case management services directly to or on behalf of a recipient, on an individual basis.

2.21 Centers for Medicare and Medicaid Services (CMS)

Federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

2.22 Clean Claim

A claim completed in accordance with Florida Medicaid billing guidelines, accompanied by all documentation required by federal or state law or state administrative rule for payment, and which may be processed and adjudicated without obtaining additional information from the provider or from a third-party, including a claim that originated in AHCA's claim system. It does not include a claim from a provider who is under investigation for fraud, abuse, or violation of state or federal Medicaid laws, rules, regulations, policies, or directives, or a claim under review for medical necessity.

- 2.23 Clearinghouse**
Third-party entity that transmits claims created by a provider.
- 2.24 Coinsurance**
The amount that a Medicare beneficiary (or other third-party) pays to a provider for furnishing medical or allied care, goods, or services.
- 2.25 Consultation**
Opinion rendered by a health professional at the request of another health professional.
- 2.26 Contractor**
Any entity under contract with AHCA including all employees, subcontractors, agents, volunteers, and anyone acting on behalf of, in the interest of, or for a contractor.
- 2.27 Controlling Interest**
As defined in 42 CFR 455.101.
- 2.28 Copayment**
The amount a recipient is required to pay a provider for furnishing Florida Medicaid covered services.
- 2.29 Corrective Action Plan (CAP)**
Written plan of action developed by the cited entity to correct cited deficiencies in compliance with federal or state regulations, rules, or policies.
- 2.30 Cost-based Reimbursement**
Reimbursement based on the provider's actual costs for rendering Florida Medicaid covered services to recipients.
- 2.31 Coverage Policy**
A policy document that contains coverage information about a Florida Medicaid service (also known as a Handbook).
- 2.32 Covered Services**
Medical and allied care, goods, services, or procedures that are reimbursable by Florida Medicaid.
- 2.33 Current Procedural Terminology (CPT®) codes**
Systematic listing and coding of procedures and services published yearly by the American Medical Association. CPT® is a registered trademark of the American Medical Association.
- 2.34 Date of Service (DOS)**
Date the provider furnished a Florida Medicaid covered service to a recipient, unless otherwise specified.
- 2.35 Diagnosis and Procedure Codes**
The most current edition of the International Classification of Diseases, which is a method of classifying written descriptions of diseases, injuries, conditions, and procedures using alphabetic and numeric designations or codes.
- 2.36 Diagnosis-Related Groups (DRG)**
A payment method which involves classifying inpatient stays and determining a price based on a combination of the classification and the hospital where the services were performed.

2.37 Disclosing Entity

As defined in 42 CFR 455.101.

2.38 Disenrollment

The discontinuance of an enrollee's membership in a managed care plan or of an enrollee's participation in a federally-approved waiver program.

2.39 Dually Eligible Recipient

Any person who is eligible to receive benefits under the Florida Title XIX Medicaid program, and the federal Title XVIII Medicare program.

2.40 Electronic Data Exchange Vendor

Any third-party entity that transmits Health Insurance Portability and Accountability Act (HIPAA) covered transactions on behalf of an enrolled provider.

2.41 Eligible Person

See Recipient.

2.42 Emergency Care, Emergency Medical Services, or Emergency Services

Medical screening, examination, and evaluation by a physician or, if applicable, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists; and if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

2.43 Enrollee

Recipient who is a member of a managed care plan.

2.44 Established Patient

Recipient who has received professional medical or allied care, goods, or services from the provider within the past three years.

2.45 Examination

The evaluation of a recipient by a health care practitioner during the process inherent to the diagnosis and treatment of any disease, complaint, or disorder.

2.46 Experimental or Experimental and Clinically Unproven or Investigational

Related to drugs, devices, medical treatments, or procedures when:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished.
- Reliable evidence shows the drug, device, medical treatment, or procedure is the subject of on-going phase I, II or III clinical trials, or under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows the consensus among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis.
- The drug or device is used for a purpose that is not approved by the FDA.

2.47 Explanation of Medicaid or Medicare Benefits (EOB or EOMB)

Statement mailed to a recipient, beneficiary, or provider explaining the payment of his or her claim.

2.48 Fair Hearing

As defined in Rule 59G-1.100, F.A.C.

2.49 Fee-for-Service

Method of reimbursement for Florida Medicaid covered services based on fees set by AHCA for defined care, goods, or services.

2.50 Fee-For-Service Delivery System

The mode by which providers who are enrolled in Florida Medicaid receive reimbursement for Florida Medicaid covered services rendered to recipients who are not enrolled in a managed care plan.

2.51 Felony

As defined in section 775.08, F.S.

2.52 Fiscal Year

July 1 through June 30.

2.53 Florida Medicaid Management Information System (FMMIS)

Computer system used to process Florida Medicaid claims and encounter transactions to produce management information relating to the Florida Medicaid program.

2.54 Global Reimbursement

Method of payment wherein the provider is paid one fee for a service that consists of multiple procedure codes rendered on the same date of service or over a specified time period.

2.55 Goods

Appliances, equipment, supplies, or other items normally or usually recognized by medical professionals as medically necessary in the treatment of or rehabilitation from the covered illness or injury, including drugs and durable medical equipment.

2.56 Grievance

As defined in 42 CFR 438.400.

2.57 Group or Group Practice

Two or more health care practitioners who practice at a common location, whether or not they share common facilities, supporting staff, or equipment, whose organization possesses a common federal employer identification number (FEIN).

2.58 Healthcare Common Procedure Coding System (HCPCS)

Common procedure coding system administered by the Centers for Medicare and Medicaid Services that is used by health care providers to identify the services performed.

2.59 Health Insurance Portability and Accountability Act (HIPAA)

Federal law that protects health insurance coverage for workers and their families when they change or lose their jobs. The federal laws include the HIPAA Privacy Rule, the HIPAA Security Rule, and the HIPAA Breach Notification Rule, to protect the privacy of an individual's health information; set national standards for the security of protected health information sent electronically; and to require notification following a breach of unsecured protected health information.

2.60 Home and Community-based Services Waiver

Specific program and set of Florida Medicaid covered services authorized under section 1915(c) of the federal Social Security Act designed to assist recipients in receiving services in their home and the community and to avoid institutionalization.

2.61 Independent

Not under common control or governance, direct or indirect ownership.

2.62 Indirect Ownership Interest

As defined in 42 CFR 455.101.

2.63 Inpatient

Recipient who has been admitted to a hospital for hospital services with the expectation of remaining at least overnight and occupying a bed even though the recipient may be discharged or transferred to another hospital and may not use the hospital bed overnight.

2.64 Instrumental Activities of Daily Living (IADLs)

IADLs include:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- Medication management
- Money management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

2.65 Insurer

Entity authorized to furnish health care or health care insurance coverage.

2.66 Internal Control Number (ICN)

Thirteen digit number assigned to each claim when it is received by the fiscal agent for processing.

2.67 Investigation

Activities to determine if issues of non-compliance exist with the laws, rules, or policies governing Florida Medicaid, and other laws wherein AHCA has authority.

2.68 Leave Days

When a recipient is absent from the provider's setting overnight for an allowable reason.

2.69 Legal Representative

As defined in section 409.901, F.S.

2.70 Level of Care

A determination of clinical eligibility for a Florida Medicaid program or waiver.

2.71 Licensed

Facility, equipment, system(s), or an individual that has formally met and is registered in accordance with all applicable federal, state, county, and local requirements, and has authorization from the applicable competent authority to perform an act which, without such authorization, would be illegal.

2.72 Locum Tenens Provider

Provider who substitutes on a temporary basis for another provider while the permanent provider is indisposed and must enroll in Florida Medicaid as an individual treating provider before services may be reimbursed.

2.73 Long-term Care Plan

Managed care plan that provides services in accordance with section 409.98, F.S., for the long-term care program of the Statewide Medicaid Managed Care program.

2.74 Managed Care Plan

As defined in section 409.962, F.S.

2.75 Managed Medical Assistance Plan

Managed care plan that provides services in accordance with section 409.973, F.S., for the medical assistance program of the Statewide Medicaid Managed Care program.

2.76 Managing employee

General manager, business manager, administrator, director, or other person who exercises operational or managerial control of a provider, or who directly or indirectly conducts the day-to-day operations of a provider.

2.77 Medicaid Agency

As defined in section 409.901(1), F.S. In Florida, the Medicaid agency is AHCA.

2.78 Medicaid Fraud Control Unit (MFCU)

Unit in the Office of the Attorney General of Florida designated to investigate and prosecute fraud involving providers that intentionally defraud the state's Medicaid program through fraudulent billing.

2.79 Medicaid Identification Card (ID)

Card furnished to recipients that is used by providers to verify eligibility.

2.80 Medicaid-related Records

Records that relate to the provider's business or profession and to a recipient. Medicaid-related records also include records related to non-Medicaid customers, clients, or patients, to the extent that the documentation is shown by AHCA to determine a provider's entitlement to payments under the Florida Medicaid program.

2.81 Medical Assistance

Any provision of, payment for, or liability for medical or allied care, goods, or services by Florida Medicaid to, or on behalf of, any recipient.

2.82 Medical Records

Documents corresponding to Florida Medicaid covered services furnished in any place of service.

2.83 Medically Necessary or Medical Necessity

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Medically necessary or medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

2.84 Medically Needy

Florida Medicaid coverage group (also referred to as share-of-cost) that includes individuals who would qualify for Medicaid, except that their income or resources exceed Florida Medicaid's income or resource limits.

2.85 Medicare

Medical assistance program authorized by Title XVIII of the federal Social Security Act, 42 U.S.C. section 1395 et seq., and regulations thereunder.

2.86 Multidisciplinary Team

Group consisting of representatives from all professional disciplines involved in the care of an individual and participating in the development and implementation of an individual medical, nursing, rehabilitative, or active treatment plan to achieve a unified and integrated program for meeting the individual's needs.

2.87 National Provider Identifier (NPI)

Unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number).

2.88 New Patient

Recipient who has not received any professional medical or allied care, goods, or services from the provider or the provider group within the past three years.

2.89 Newborn

Infant from birth through the first four weeks of life.

2.90 Nursing Home

"Nursing home facility," as defined in section 400.021, F.S.

2.91 Officer

High-ranking person in a given corporation (business entity); normally appointed by the board of directors.

2.92 Optional Coverage Groups

Groups of individuals who may, at the option of the Florida legislature, be covered by Florida Medicaid in accordance with the provisions of federal law and Chapter 409, F.S.

2.93 Overpayment

As defined in section 409.913, F.S.

2.94 Ownership Interest

As defined in 42 CFR 455.101.

2.95 Palliative Care

An approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment, and treatment of pain and other problems, physical, psychosocial, and spiritual.

2.96 Patient Responsibility

The portion of a recipient's monthly income, as determined by the Department of Children and Families, that the recipient is responsible to pay to the nursing facility, intermediate care facility for individuals with intellectual disabilities, hospice, or toward home and community-based services.

2.97 Person(s)

Natural persons, corporations, partnerships, associations, clinics, groups, and all other similar entities.

2.98 Personal Needs Allowance

Portion of a recipient's monthly income that he or she is allowed to keep to pay for incidental expenses when residing in a residential or institutional setting.

2.99 Physical Examination

Personal, face-to-face contact with a recipient by a licensed physician or by another licensed medical professional under the supervision of a physician, for the purpose of diagnosis and treatment of medical disorders.

2.100 Place of Service (POS)

Physical location where a provider renders Florida Medicaid covered services to, or for, a recipient.

2.101 Plan of Care (POC) or Plan of Treatment

Individualized written program for a recipient developed by health care professionals based on the need for medical care established by the attending physician and designed to meet the medical, health, and/or rehabilitation needs of a recipient.

2.102 Post Authorization

Approval for Florida Medicaid covered services after the services have been rendered to a recipient.

2.103 Primary Care

Comprehensive, coordinated, and readily-accessible medical care, furnished at the recipient's first point of contact with the health care system, including health promotion and maintenance, treatment of illness and injury, early detection of disease, and referral to specialists when appropriate.

2.104 Principal

Any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to five percent or more in the provider.

2.105 Procedure Code

Number that Florida Medicaid uses to identify the procedures that providers render to recipients.

2.106 Provider

The term used to describe any entity, facility, person, or group that is enrolled to furnish services under the Florida Medicaid program.

2.107 Provider Agreement or Provider Agreement Contract

Contract between AHCA and a provider for the furnishing of Florida Medicaid covered services to recipients.

2.108 Quality Improvement Organization (QIO) or QIO-like Entity

Entity designated through the Centers for Medicare and Medicaid Services to perform utilization review services and to monitor the appropriateness of care provided to individuals through a state Medicaid program.

2.109 Rate

The reimbursement amount specified on the applicable Florida Medicaid fee schedule, posted on AHCA's Web site for cost-based services, or the mutually agreed upon amount between AHCA and the provider, for a Florida Medicaid service.

2.110 Recipient

Individual determined to be eligible for Florida Medicaid covered services by the Department of Children and Families or the Social Security Administration, and who is enrolled in the Florida Medicaid program.

2.111 Records

See Business Records, Medicaid-related Records, and Medical Records.

2.112 Recoupment

Process by which AHCA recovers an overpayment or inappropriate payment from a Florida Medicaid provider.

2.113 Reliable Evidence

Published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the facility or the protocol(s) of another facility studying substantially the same drug device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug device or medical treatment or procedure.

2.114 Resident

Individual who resides in a facility as defined in section 400.021, F.S.

2.115 Risk or Underwriting Risk

Potential for loss that is assumed by a contractor and that may arise because the cost of providing care, goods, or services may exceed the capitation or other payment made by AHCA to the contractor under terms of the contract.

2.116 Routine

Medications, treatments, care, goods, or services furnished in accordance with an established or predetermined schedule, and performed for recipients whose medical needs are stabilized or chronic.

2.117 Screen, Screening, or Screening Services

Assessment of a recipient's physical or mental condition to determine the need for further evaluation or services.

2.118 Self-audit

Review of claims a provider conducts on its own to ensure compliance with Florida Medicaid rules.

2.119 Service(s)

Any diagnostic or treatment procedure(s) or other medical or allied care claimed to have been furnished to a recipient and listed in an itemized claim for payment; or, in the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim.

2.120 Service Limit or Service Limitation

Maximum amount, duration, or scope of a Florida Medicaid covered service.

2.121 Specialty Plan

As defined in section 409.962, F.S.

2.122 Statewide Medicaid Managed Care

A service delivery system created in Part IV, Chapter 409, F.S. consisting of the:

- Long-term care program as described in section 409.978, F.S.
- Managed medical assistance program as described in section 409.971, F.S.

2.123 Subcontract

Written agreement entered into by a contractor for provision of services on its behalf.

2.124 Subcontractor

Any person or entity to which a provider or contractor has contracted or delegated some of its management functions or its responsibilities for providing medical or allied care, goods, or services; or its claiming or claims preparation or processing functions, or responsibilities.

2.125 Suspension

Exclusion of a provider by AHCA from further participation in the Florida Medicaid program for a specific period of one year or less, after which the provider must apply for reenrollment in order to participate in the Florida Medicaid program.

2.126 Swing Bed

Bed in a rural hospital licensed pursuant to Chapter 395, F.S., that can also be used for skilled or intermediate nursing care services.

2.127 Termination

Exclusion by AHCA of a provider from further participation in the Florida Medicaid program for a period of one year to twenty years.

2.128 Therapeutic Leave

A non-medical visit outside the facility used for overnight visits with family or friends.

2.129 Third-party Payment

Performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical or allied care, goods, or services.

2.130 Treating Provider

Individual provider who personally renders Florida Medicaid covered services, or assumes responsibility for rendering Florida Medicaid covered services, through personal supervision, on behalf of a Florida Medicaid group provider.

2.131 Treatment Plan

See Plan of Care (POC).

2.132 Treatment Services

Corrective, therapeutic, or restorative services furnished as a result of a diagnosis identified during a screening.

2.133 Vendor

Individual or entity that engages in the business of selling care, goods, services, or commodities.

2.134 Visit

Face-to-face contact between a health care practitioner and a recipient that takes place at a center, office, home, or other place of service.

2.135 Void

Negation of an original payment.