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.

This policy is intended for use by all providers that render services to eligible Florida Medicaid recipients, unless otherwise specified. For recipients enrolled in a managed care plan, providers should also refer to the recipient's managed care plan for additional related definitions. This policy must be used in conjunction with Florida Medicaid's general policy, and any applicable service-specific and claim reimbursement policies with which providers must comply.


Definitions

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

2. **Active treatment plan**
   Written plan of care or service implementation plan specific to an individual that sets forth measurable goals or objectives stated in terms of desirable behavior and prescribing an integrated program of activities, experiences, or therapeutic interventions necessary for an individual to reach those goals or objectives. Applied to the community behavioral program services, services for individuals with intellectual disabilities (IID), in the nursing home, and in an intermediate care facility (ICF/IID), an active treatment plan focuses on treatment and services to address mental illness.

3. **Adjudicate**
   Make an official decision.

4. **Adjusted claim**
   A claim to correct a previous payment.

5. **Adjustment**
   Process or the result of the process by which a previous payment is corrected.

6. **Administrative hearing**
   Formal or informal proceeding held in accordance with the provisions of Chapter 120, F.S.

7. **Administrative days**
   Days a recipient remains in the hospital beyond the point of medical necessity while awaiting placement in a nursing facility or other place of residence.

8. **Administrative sanctions**

9. **Admission review**
   Evaluation of an individual's need for institutional care, goods, or services in accordance with established medical care and related criteria, including a determination of whether community based care is a viable alternative to institutionalization.

10. **Adverse continued stay decision**
    Decision based on an assessment of an individual's medical and related needs, that terminates institutional care or services, or terminates payment to a provider.

11. **Affiliate or affiliated person**
    Any person who directly or indirectly manages, controls, or oversees the operation of a corporation or other business entity that is a Florida Medicaid provider, regardless of whether such person is a partner, shareholder, owner, officer, director, agent, or employee of the entity.

12. **Agency**
    Agency for Health Care Administration (AHCA).
13. **Allied care**
   Care related to the health care needs of Florida Medicaid recipients.

14. **Allowable costs**
   An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with the Principles of Reimbursement for Provider Costs, as defined in the Centers for Medicare and Medicaid Services’ Provider Reimbursement Manual Pub. 15-1, and the Florida Title XIX Reimbursement Plans.

15. **Alternative placement**
   Placement of a recipient in any setting other than an institution.

16. **Appeal**
   A request for a Florida Medicaid fair hearing, an administrative hearing, or review of AHCA’s action by a court of competent jurisdiction.

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

18. **Applicant, recipient**
   A prospective recipient 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 their behalf.

19. **Approved application**
   An accurately and fully completed application from an applicant that meets all the Florida Medicaid enrollment requirements.

20. **Attending physician**
   Doctor of medicine or osteopathy identified as having primary responsibility for a recipient’s medical care.

21. **Audit**
   An 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.

22. **Baker Act**
   Florida Mental Health Act, Chapter 394, F.S.

23. **Bed hold**
   Florida Medicaid payment to a facility to reserve a bed in a facility while a recipient is in the hospital or on therapeutic leave.

24. **Beneficiaries**
   Persons receiving medical benefits under Medicare.

25. **Benefit**
   Any assistance, aid, obligation, promise, debt, liability, or the like related to any covered injury, illness, or necessary medical or allied care, good(s), or service(s).

26. **Billing agent**
   Florida Medicaid-enrolled entity that offers claims submission services to providers.

27. **Billing practitioner**
   Entity that submits a claim on behalf of a Florida Medicaid provider who has provided medical or allied care, goods, or services.

28. **Board certified**
   Certified by a medical specialty board; approved by the American Association of Physician Specialists, American Board of Optometry, American Osteopathic Board of Neurology and Psychiatry, American...
Board of Psychiatry and Neurology, American Board of Medical Specialties, or American Osteopathic Association; or certified by a dental specialty board of the American Dental Association.

29. Bribe, kickback, or illegal solicitation
   (a) Knowingly and willfully soliciting or receiving any remuneration directly or indirectly, overtly or covertly, in cash or in kind, from any person in return for:
      • Referring or taking an individual to a person for the furnishing or arranging for the furnishing of, any item or service for which payment may be made in whole or in part under the Florida Medicaid or other health care program, unless such arrangement has been made with or approved by AHCA.
      • Purchasing, leasing, ordering or arranging for, or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under the Florida Medicaid or other health care program, unless such arrangement has been made with or approved by AHCA.
   (b) Knowingly or willfully offering or paying any remuneration directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce such person to:
      • Refer or take an individual to a person for the furnishing or arranging for the furnishing of, any item or service for which payment may be made in whole or in part under the Florida Medicaid or other health care program, unless such arrangement has been made with or approved by AHCA.
      • Purchase, lease, order, arrange for any recommended purchase, lease, or order of any good, facility, service, or item for which payment may be made in whole or in part under the Florida Medicaid or other health care program, unless such arrangement has been made with or approved by AHCA.

30. Business records
   Documents related to the administrative or commercial activities of a provider. Business records made available to Florida Medicaid must be dated and legible. Business records include, as applicable, admission, accident, appointment, assignment, billing, contract, eligibility, financial, insurance, legal, medical release, patient activity, peer review, personnel, procurement, registration, signature authorization, tax, third-party correspondence, utilization review documents; all administrative or commercial records that are customarily prepared or acquired and are customarily retained by the provider; and administrative or commercial records that are required by statute or rule to be prepared or acquired and retained by the provider. Records may be on paper, magnetic material, film, or other media.

31. Cap
   See Service limit.

32. Cap period
   See Service limitation period.

33. Capitation payment
   Fee paid by AHCA for each recipient enrolled with the provider for the provision of Florida Medicaid services, whether or not the enrollee receives the services during the payment period.

34. Care plan
   See Plan of care or Plan of treatment.

35. Case management
   Manner or practice of planning, directing, and coordinating the recipient’s health care and utilization of medical and allied services.

36. Case manager
   Individual who furnishes care coordination services directly to or on behalf of a recipient, on an individual basis.
37. Centers for Medicare and Medicaid Services
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.

38. Certification
Process of determining whether a facility, equipment, or an individual meets the requirements of federal or state law, or whether Florida Medicaid payments are appropriate or payable.

39. Certification statement
Statement by a physician or other authorized professional attesting to an individual's need for a specific type or level of coverage under the Florida Medicaid program.

40. Children's Medical Services Network (CMSN)
Managed system of care administered by the Florida Department of Health (DOH) for recipients under the age of 21 years with special health care needs.

41. Claim
A communication, whether oral, written, electronic, or otherwise conveyed, used to request payment from the Florida Medicaid program for goods or services furnished to Florida Medicaid recipient(s).

42. Claims detail
A report concerning claims submitted to Florida Medicaid.

43. 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.

44. Clearinghouse
Third-party entity that transmits claims created by a provider.

45. Client assessment or reassessment
Formal tools or informal techniques used by a health care provider or case manager to identify the medical, social, educational, or other needs of a recipient.

46. Coinsurance
The amount that a Medicare beneficiary pays to a provider for furnishing medical or allied care, goods, or services.

47. Collateral
Any and all causes of action, suits, claims, counterclaims, and demands that accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical or allied care, goods, or services for which Florida Medicaid provided medical assistance; all judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments; and proceeds as defined in section 409.901, F.S.

48. Compensable services
See Medicaid services.

49. Comprehensive Assessment and Review for Long-Term Services (CARES)
Institutional care preadmission assessment and screening program administered or arranged by the Florida Department of Elder Affairs.

50. Concurrent care
Care furnished simultaneously by physicians of more than one specialty.
51. **Concurrent days**
The days when a Florida Medicaid recipient and her newborn(s) are inpatients of the same hospital at the same time.

52. **Consultation**
Opinion rendered by a health professional at the request of another health professional.

53. **Contracting officer**
The Secretary of AHCA or designee.

54. **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.

55. **Controlling interest**
Direct or indirect possession of equity in the capital, stock, or profits of the disclosing entity.

56. **Convicted or conviction**
A finding of guilt with or without an adjudication of guilt, by any federal or state trial court relating to charges brought by indictment or information, as a result of a jury verdict, non-jury trial, or entry of a plea of guilty or nolo contendere, regardless of whether an appeal from judgment is pending.

57. **Copayment**
The amount that a Florida Medicaid recipient is required to pay a provider for furnishing medical or allied care, goods, or services.

58. **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.

59. **Cosmetic**
Furnished for aesthetic purposes.

60. **Cost-based reimbursement**
Reimbursement based on the provider’s actual costs for rendering services to Florida Medicaid recipients; also referred to as a per diem rate or an encounter rate.

61. **Coverage policy**
A policy document that contains coverage information about a Florida Medicaid service (also known as a Handbook).

62. **Covered injury or illness**
Any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third-party is, may be, could be, should be, or has been liable, and for which Florida Medicaid is or may be obligated to provide or has provided, medical assistance.

63. **Covered services**
Medical or allied care, goods, or services determined by AHCA to be eligible for reimbursement pursuant to Florida Medicaid program standards; and, those Medicaid and other medical or allied care, goods, or services that a managed care plan agrees to furnish under the terms of its contract with AHCA.

64. **Covered procedures**
See Medicaid services.

65. **Crossover or crossover claim**
Claim submitted to Medicare and subsequently submitted to Florida Medicaid for payment of the Medicare deductible or coinsurance in an amount up to the Florida Medicaid rate. If Medicare paid more than Florida Medicaid’s fee for the service, there is no Florida Medicaid payment.

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.
67. Custodial care
   Care without the provision of continued medical or paramedical attention, given to assist a person in performing daily living activities.

68. Date of service (DOS)
   Date the provider furnished medical or allied care, goods, or services to a Florida Medicaid eligible recipient, unless specified otherwise for a particular service.

69. Diagnosis and evaluation (D & E)
   A comprehensive assessment of a person’s performance level in several health, social, mental, and personal abilities by an interdisciplinary team of professionals. The D & E includes a detailed listing of the individual’s service needs and a care or service plan that includes the services the individual requires to attain measurable objectives.

70. Diagnosis and evaluation (D & E) team
   An interdisciplinary team of professionals that evaluates an individual to determine eligibility for developmental services, service needs, and develop a plan of care for the provision of needed medical or allied care, goods, or services for the individual.

71. 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.

72. Diagnosis-related groups reimbursement
   Classification system that groups similar clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay.

73. Directive
   Any statement of general instruction regarding procedure(s) AHCA communicates to a provider through handbooks, manuals, guidelines, bulletins, letters, and other types of communication which AHCA determines to be appropriate to apprise a provider of its compliance requirements.

74. Directors
   Members of the company's board of directors.

75. Disclosing entity
   Florida Medicaid provider (except an individual practitioner or group of practitioners or a fiscal agent) that furnishes services, or arranges for funding of services or health-related services under Florida Medicaid.

76. Disenrollment
   The discontinuance of an enrollee’s membership in a contractor's prepaid plan; of an enrollee’s participation in a provider’s enrolled caseload; or of an enrollee’s participation in a federally-approved waiver program.

77. Disproportionate share hospital
   Hospital that serves a disproportionately large number of low-income patients with special needs in comparison to other hospitals.

78. Drug efficacy study implementation (DESI)
   Used to identify drug products and known related-drug products that have been identified by the Centers for Medicare and Medicaid Services as lacking substantial evidence of effectiveness.

79. Drug utilization review (DUR)
   Process whereby the pharmacist reviews the prescription and the patient record for therapeutic appropriateness.

80. District
   A geographic service area of AHCA, defined in section 20.19, F.S.

81. Drug exception request (DER)
   Process wherein a change to a recipient’s monthly drug service limit may be allowed.
82. **Dually eligible recipient**  
Any person who is eligible to receive benefits under the Florida Medicaid program, Title XIX, and the federal Medicare program, Title XVIII.

83. **Durable medical equipment (DME)**  
Medical equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose; is generally not useful in the absence of illness or injury; and is appropriate for use in the patient’s home.

84. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program**  
Program administered by Florida Medicaid to provide comprehensive and preventive health care services for Florida Medicaid-eligible children under the age of 21 years.

85. **Election**  
Selection of hospice services by the individual or the individual’s representative.

86. **Elective surgery**  
Surgery that can be safely deferred without:

- Threatening the life of the patient.
- Causing irreparable physical damage.
- Resulting in irretrievable loss of growth and development.
- Resulting in the loss or serious impairment of a body function.

87. **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.

88. **Eligible person**  
See Recipient.

89. **Eligibility vendor**  
Any third-party entity that verifies recipient eligibility on behalf of enrolled providers.

90. **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.

91. **Emergency medical condition**  
Physical or mental condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, including a pregnant woman or a fetus; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

92. **Emergency Medical Treatment and Labor Act (EMTALA)**  
Federal statute requiring emergency rooms to conduct a medical screening exam on any patient presenting to the emergency room for medical services, to determine if an emergency medical condition exists. If the screening determines that an emergency medical condition exists, the provider must either stabilize the condition or appropriately transfer the patient to a facility that can stabilize the condition.

93. **Encounter**  
Interaction between a patient and provider (health plan, rendering physician, pharmacy, lab, etc.) who delivers services, or is professionally responsible for services delivered to a patient.

94. **Encounter claim**  
Individual transaction containing a record of diagnostic or treatment procedures, or other medical or allied care provided to a health plan’s enrollees, excluding services paid by Florida Medicaid on a fee-for-service basis.
95. **Enrollee**
Florida Medicaid-eligible recipient who is a member of a managed care plan, or a federally approved waiver program.

96. **Erroneous payment**
Payment made to a Florida Medicaid recipient, provider, or other person to which the payee is not entitled, and which is caused by intentional or inadvertent error by the recipient, provider, or other person.

97. **Established patient**
Patient who has received professional medical or allied care, goods, or services from the provider within the past three years.

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

99. **Exception or exception authorization**
Determination by AHCA allowing for the provision of and payment for medical or allied care, goods, or services that otherwise would not be reimbursable due to service limitations.

100. **Expanded benefit**
Covered service of a managed care plan that either is not a Florida Medicaid-covered service, or is a Florida Medicaid-covered service for which the plan receives no capitation payment.

101. **Experimental or experimental and clinically unproven or investigational**
Related to drugs, devices, medical treatments, or procedures means that:
- 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 ongoing phase I, II or III clinical trials, or under study to determine its maximum tolerated dose, toxicity, safety, efficacy 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.

102. **Explanation of Medicaid or Medicare benefits (EOB or EOMB)**
A statement mailed to a recipient, beneficiary, or provider explaining the payment of his or her claim.

103. **Factor**
An individual or organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable.

104. **Fair hearing**
Opportunity afforded to any Florida Medicaid applicant or recipient when there has been a determination to deny, reduce, or terminate benefits or services, except when the determination is due solely to a law or policy requiring an automatic change, to have impartial official(s) not directly or indirectly involved in the initial determination of the action in question, render a final decision based on information submitted for review, pursuant to the hearing standards contained in federal regulations.

105. **Family service plan or Family support plan (FSP)**
Plan of care for the entire family including health care, economic assistance, equipment, and education which has been accepted by AHCA.
106. Fee-for-service
   Method of reimbursement for medical or allied care, goods, or services based on fees set by AHCA for defined care, goods, or services.

107. Felony
   An act that:
   - Is a felony under Florida law or would be punishable as a felony had the act been committed in Florida.
   - Is a felony under federal law or would be punishable as a felony had the act been committed under federal jurisdiction.
   - Is a crime, typically one involving violence, regarded as more serious than a misdemeanor, and which may be punishable by imprisonment for more than one year up to death, based upon the crime.

108. Fiscal agent
   Any corporation or other legal entity that has contracted with AHCA to receive, process, and adjudicate claims under the Florida Medicaid program.

109. Fiscal year
   A twelve month budgetary, financial reporting, or cost-accounting time period, used by AHCA, health care providers, the Florida Legislature, and the federal government. The state fiscal year is July 1 through June 30, and the federal fiscal year is October 1 through September 30.

110. Florida Medicaid Management Information System (FMMIS)
   Computer system used to process Florida Medicaid claims and to produce management information relating to the Florida Medicaid program.

111. Fraud
   Intentional deception or misrepresentation by an individual with the knowledge that the deception could result in some unauthorized benefit to him- or herself or another. It includes any act that constitutes fraud under applicable federal or state law.

112. Freedom of Choice
   The right of a Florida Medicaid recipient to choose from all programs for which he or she is eligible and to choose any enrolled or registered Florida Medicaid provider, as applicable, from whom to obtain medical or allied care, goods, or services.

113. Full benefit dual eligible
   Recipient who has both Medicare and full Florida Medicaid, including recipients who are eligible for the Medically Needy program. Full benefit dual eligible recipients may or may not be eligible for qualified Medicare beneficiary (QMB) status. Full benefit duals who are not QMB do not receive the same level of benefits as someone who has full benefits as dual eligible with QMB.

114. Furnished
   Supplied, given, prescribed, ordered, provided, or directed to be provided in any manner.

115. 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.

116. 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.

117. Grace days
   See Administrative days.
118. **Grievance**
   Formal complaint filed with AHCA by a managed care enrollee or the enrollee’s agent that expresses dissatisfaction with care, goods, services, or benefits received under the program in which the individual is enrolled.

119. **Grievance procedure**
   Organized process by which managed care enrollees may express dissatisfaction with care, goods, services, or benefits received under the program in which they are enrolled and the resolution of these dissatisfaction.

120. **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).

121. **Habilitation plan or Individual support plan**
   Plan for providing programs and services to an individual based on a joint interdisciplinary professional diagnosis and evaluation process, consisting of a complete medical, social, and psychological assessment. The habilitation plan identifies barriers to optimum independent functioning and targets behaviors to be achieved by the individual over a specified period, also providing the basis for the development of the active treatment plan.

122. **Healthcare Common Procedure Coding System (HCPCS)**
   Common procedure coding system used by health care providers to identify the services performed. The coding system is administered by the Centers for Medicare and Medicaid Services.

123. **Health coverage**
   Health insurance, disability insurance, multiple employer welfare arrangements, health maintenance organizations, or prepaid health clinics defined in sections 624.603, 624.437, 641.19(512), and 641.402(4), F.S.

124. **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 HIPPA Security Rule; and the HIPPA 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.

125. **Health maintenance organization (HMO)**
   An entity certified by the Florida Department of Insurance under applicable provisions of Chapter 641, Part II, F.S., or as defined in the Florida Medicaid State Plan.

126. **High medical risk pregnant woman**
   Woman whose medical history and diagnosis indicate, without consideration of a previous caesarean section, that a normal uncomplicated pregnancy and delivery is unlikely to occur.

127. **Home and community based services waiver**
   Specific program and set of services authorized under section 1915(c) of the Social Security Act designed to assist recipients avoid institutionalization.

128. **Illegal solicitation**
   See Bribe, kickback, or illegal solicitation.

129. **Inappropriate payment**
   Any portion or all of a payment made to any person or provider to which the payee is not entitled, as determined by Florida Medicaid.

130. **Independent**
   Not under common control or governance, direct or indirect ownership.

131. **Indirect ownership interest**
   Ownership interest in an entity that has an ownership interest in another entity.
132. **Individual support plan or Individualized family support plan**
Florida Medicaid accepted plan of care for a recipient written by the recipient’s family and service and health care providers. The plan identifies the recipient’s health care, economic assistance, equipment, and educational needs. (See Habilitation plan).

133. **Infirmary**
Designated area of a facility where the infirm or sick are lodged for temporary care or treatment.

134. **Initial Medicaid interim reimbursement rate**
The interim rate(s) established based on a budgeted cost report submitted by the Florida Medicaid provider. The interim rates will be subjected to cost settlement once the actual cost report is filed with the Bureau of Medicaid Program Finance.

135. **Inpatient**
Recipient who has been admitted to a hospital for inpatient 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.

136. **Insolvency**
Financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business; or, when the liabilities of the entity exceed its assets.

137. **Inspection of care**
Periodic on-site review and evaluation of care and services furnished to Florida Medicaid residents by institutional care facilities.

138. **Institutional Care**
Recipient services furnished in an institutional care facility.

139. **Institutionalized person**
Person who is:
- Involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness.
- Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
- A resident of or admitted to an institution.

140. **Insurer**
Entity authorized to furnish health care or health care insurance coverage.

141. **Interdisciplinary 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, and active treatment plan to achieve a unified and integrated program for meeting the individual’s needs.

142. **Intermittent or intermittent nursing care**
A medically predictable need for care, goods, or services to be provided from time to time, but usually not less frequently than once every sixty days, and needed on an acute episodic basis but not a maintenance basis. The fact that a provider has used the term “intermittent” in furnishing, prescribing, recommending, or approving care, goods, or services does not, in itself, make such care, goods, or services intermittent for Florida Medicaid purposes.

143. **Internal control number (ICN)**
Thirteen digit internal control number assigned to each claim when it is received by the fiscal agent for processing.

144. **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.
145. **Kickback**

See Bribe, kickback, or illegal solicitation.

146. **Knowingly**

When a person is aware or should be aware of the nature of his or her conduct, and that his or her conduct is substantially certain to cause the result at issue.

147. **Legal representative**

Guardian, conservator, survivor, or personal representative of a recipient or applicant, or of the property or estate of a recipient or applicant.

148. **Legend drugs**

Drugs for which federal law requires the federal legend label, “Caution: Federal law prohibits dispensing without a prescription”, or those drugs that state law prohibits dispensing without a prescription.

149. **Level of care**

The level of nursing or rehabilitative care required by a Florida Medicaid applicant or recipient based on the individual’s medical or related needs, as defined by the criteria in Chapter 59G-4, F.A.C.

150. **Licensed**

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

151. **Lock-in**

Restriction of a Florida Medicaid recipient to a single provider or health plan that is enrolled or under contract with AHCA and that agrees to be responsible for the provision or authorization of services for that recipient.

152. **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.

153. **Low medical risk pregnant woman**

Woman whose medical history and diagnosis indicate, without consideration of a previous caesarean section, that a normal uncomplicated pregnancy and delivery are likely to occur.

154. **Maintenance drugs**

Drugs prescribed for the treatment of a known chronic disorder and all drugs prescribed for longer than two consecutive months for the treatment of a disease state.

155. **Managed care plan**

Health maintenance organization authorized pursuant to Chapter 641, F.S. (Also known as a health plan).

156. **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.

157. **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.

158. **Mandatory coverage groups**

Groups of individuals required to be covered by Florida Medicaid in accordance with the provisions of federal law and Chapter 409, F.S.
159. Medicaid
Medical assistance program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. s. 1396, et seq., and regulations thereunder, as administered in Florida by AHCA under section 409.901, et seq., F.S.

160. Medicaid agency
Single state agency that administers or supervises the administration of the Medicaid state plan under federal law. In Florida, the Medicaid agency is AHCA.

161. Medicaid Fiscal Agent Operations (FAO)
Bureau within AHCA responsible for overseeing all activities of the Florida Medicaid fiscal agent.

162. 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.

163. Medicaid identification card (ID)
Card furnished to Florida Medicaid recipients that is used by providers to verify eligibility.

164. Medicaid physician consultant
Doctor of medicine or osteopathy licensed pursuant to Chapter 458 or Chapter 459, F.S., employed by or under contract with Florida Medicaid.

165. Medicaid-related records
Records that relate to the provider’s business or profession and to a Florida Medicaid recipient, including 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.

166. Medicaid services, Medicaid care, or Medical services
Medically necessary medical or allied institutional or noninstitutional care, goods, services, or procedures, covered and eligible for payment, by the Florida Medicaid program.

167. 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.

168. Medical care
See Medicaid services.

169. Medical care evaluation study
Study performed by a facility’s utilization review committee that identifies and analyzes patterns of care furnished to Florida Medicaid inpatient hospital residents.

170. Medical records
Documents corresponding to medical or allied care, goods, or services furnished in any place of service. (Also see Business records and Medicaid-related records).

171. Medical review
Process by which certain claims submitted to the Florida Medicaid fiscal agent for payment are reviewed by medical consultants to determine their final adjudication.

172. Medical supplies
Medical or surgical items that are consumable, expendable, disposable, or non-durable and that are used for the treatment or diagnosis of a patient’s specific illness, injury, or condition.

173. Medically necessary or medical necessity
The medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
2. 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

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational

4. 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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

(b) 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.

(c) 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.

174. 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. Based on monthly medical expenses, the individual may qualify for Florida Medicaid for the day he or she became eligible until the end of the month.

175. 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.

176. Mental health treatment
Mental health services that are furnished to persons, individually or in groups, including counseling, supportive therapy, intensive psychotherapy, and such other accepted therapeutic processes as qualify for Florida Medicaid reimbursement.

177. Mentally incompetent person
Individual who has been declared mentally incompetent by a court of competent jurisdiction for any purpose, unless the person has been declared competent for purposes that include the ability to consent to the specific medical procedure in question.

178. Misdemeanor
Any act that:
- Is a misdemeanor under Florida law or would be punishable as a misdemeanor had the act been committed in Florida.
- Is a misdemeanor under federal law or would be punishable as a misdemeanor had the act been committed under federal jurisdiction.

179. Misutilization
Utilization of, or the furnishing of and billing for, Florida Medicaid services that are inappropriate or unnecessary, or are not furnished in accordance with generally accepted professional standards of health care.

180. Monitor
To perform an evaluation of a provider’s practice.

181. National drug code
Eleven-digit code from the package of the dispensed drug.

182. 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).

183. **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.

184. **Newborn**
Infant from birth through the first four weeks of life.

185. **Non-clinical in-home mental health care services**
Medically necessary therapeutic services that address the special mental health needs of Florida Medicaid eligible children and furnished as a component of a care plan.

186. **Non-contract provider**
Person, organization, agency, or entity that is not directly or indirectly employed by a contractor or any of its subcontractors.

187. **Office of Health Facility Regulation**
Office designated by Florida Statutes as having responsibility for the federal certification and state licensure of a variety of health care facilities, laboratory professionals, and other service organizations.

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

189. **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.

190. **Orthotic device or orthotic**
Device or appliance to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

191. **Outpatient**
Patient of an organized medical facility or distinct part of that facility, expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

192. **Overpayment**
As set forth in section 409.913, F.S.

193. **Overutilization**
Utilization or the furnishing of and billing for Florida Medicaid care, goods, or services that are in excess of those that reasonably would be expected to benefit the health of a recipient based on the recipient’s disease or diagnosis and on generally accepted professional standards of health care.

194. **Ownership or controlling interest**
Person or corporation that:
- Has an ownership interest equal to five percent or more in a contractor or provider.
- Has an indirect ownership interest equal to five percent or more in a contractor or provider.
- Has a combination of direct and indirect ownership equal to five percent or more in a contractor or provider.
- Has an ownership interest equal to five percent or more in any mortgage, deed of trust, note, or other obligation secured by the contractor or provider, if that interest equals to five percent of the value of the property or assets of a contractor or provider.
- Is an officer or director of a contractor or provider that is organized as a corporation, or is an officer or director in an entity that has an indirect ownership interest in the contractor or provider.
• Is a partner in a contractor or provider that is organized as a partnership, or is a partner in an entity that has an indirect ownership interest in the contractor or provider. (Also see Indirect ownership interest).

195. Palliative care
An approach that improves the quality of life of patients and their families 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.

196. Part-time
The care, goods, or services for a recipient are needed on a less than continuous basis, and needed on a fixed beginning date and a projected ending date determined at the time the services are ordered.

197. Patient responsibility
The portion of a Florida Medicaid recipient’s monthly income that the recipient is responsible to pay to the nursing facility, ICF/IID, or hospice.

198. Payment record
Record of claims paid to a specific provider for Florida Medicaid care, goods, or services.

199. Peer
Person who has equal professional status with a Florida Medicaid provider of a specific type or specialty. When a person with equal professional status is not reasonably available, a peer includes a person with substantially similar professional status.

200. Peer review
Evaluation of the professional practices of a Florida Medicaid provider by a peer or peers of the provider to assess the necessity, appropriateness, and quality of care furnished compared to that customarily furnished by the provider's peers and to recognized health care standards. A peer reviewer may be employed or contracted by the AHCA to provide medical or allied consulting services.

201. Peer review committee
Committee of a provider’s peers contracted with AHCA to review and report on the professional practices of the provider at the AHCA’s direction.

202. Per diem
See Cost-based reimbursement.

203. Person(s)
Natural persons, corporations, partnerships, associations, clinics, groups, and all other similar entities.

204. Personal needs allowance
The portion of a Florida Medicaid recipient’s monthly income that he or she is allowed to keep to pay for incidental expenses.

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

206. Physician check-up
Routine physical examination in the absence of a specific problem.

207. Place of service (POS)
Physical location where a provider renders Florida Medicaid care, goods, or services to or for a recipient.
208. **Plan of care 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 health and/or rehabilitation needs of a patient.

209. **Post authorization**
Approval from AHCA to bill Florida Medicaid for medical or allied care, goods, or services obtained by a provider, or from a provider under contract with AHCA to manage a client's care, after the care, goods, or services have been furnished.

210. **Prescription**
Any order for drugs, medical supplies, equipment, appliances, devices, or treatments written or transmitted by any means of communication by a licensed practitioner authorized by the laws of the state to prescribe such drugs, supplies, equipment, appliances, devices, or treatments, or by the lawfully designated agent of such practitioner, and intended to be filled, compounded, dispensed, or furnished by a person authorized by the laws of the state to do so.

211. **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.

212. **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.

213. **Prior authorization**
Approval to deliver Florida Medicaid covered medical or allied care, goods, or services in advance of providing the care, goods, or services.

214. **Procedure code**
Number that Florida Medicaid uses to identify the procedures that providers render to Florida Medicaid recipients.

215. **Proceeds**
Whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds, including insurance payable by reason of loss or damage to the collateral or proceeds. Money, checks, deposit accounts, and the like are "cash proceeds." (All other proceeds are Manchus proceeds).

216. **Professional records**
See Medical records.

217. **Protocols**
Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem, or implementing a plan of medical, nursing, psychosocial, developmental, and educational services.

218. **Provider**
Person or entity that is enrolled in or registered with the Florida Medicaid program to furnish medical care, services or supplies; or to arrange for the furnishing of such care, services or supplies; or to submit claims for such care, services or supplies for or on behalf of another person. Only a Florida Medicaid provider may order or prescribe and seek reimbursement for care, services, or supplies provided to a Florida Medicaid recipient.

219. **Provider agreement or Provider agreement contract**
Contract between AHCA and a provider for the furnishing of medical or allied care, goods, or services to recipients.

220. **Provider service network**
Integrated health care delivery system owned and operated by Florida hospitals or other providers.
221. Provider service utilization profile
Report concerning Florida Medicaid care, goods, or services billed by or reimbursed to a provider in a given time period, listing such items as number of goods or services, procedure codes, descriptions of goods or services, number of goods or services furnished per recipient, cost per item or service, and cost per recipient.

222. Public assistance specialist (PAS)
A Department of Children and Families employee responsible for determining eligibility for some categories of recipients.

223. Quality assurance
Process of assuring that the delivery of Florida Medicaid care, goods, or services is appropriate, timely, accessible, available, and medically necessary.

224. Quality improvement organization (QIO) or QIO-like 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.

225. Recertification
Renewal of certification.

226. Recipient or Medicaid recipient
Individual the Department of Children and Families, or the Social Security Administration determines is eligible for Florida Medicaid, pursuant to federal and state law, to receive medical or allied care, goods, or services for which AHCA may make payments under the Florida Medicaid program, and is enrolled in the Florida Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Florida Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Florida Medicaid has become obligated.

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

228. Records for audit
Records, business records, medical records, professional records, documents and files, on whatever media, that AHCA finds necessary to determine the correctness and propriety of cost reports, or to determine whether Florida Medicaid payments are or were due, and the amounts thereof. Such records must be furnished by providers in accordance with the provisions of sections 1128(b) and 1902(p) of the federal Social Security Act.

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

230. Reference laboratory
A laboratory used for the performance of pathological tests and services by other than the billing physician or the billing laboratory.

231. Registered agent
An individual authorized to transact business on behalf of the provider as disclosed in the entity's Articles of Incorporation filed with the Florida Department of State.

232. 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.

233. Resident
Applicant or recipient who resides in a facility.
234. Resident record
   Any file or record in the name of an individual applicant or recipient that is maintained in the facility
   where he or she resides or has resided.

235. Responsible physician
   Licensed physician delegated by the supervising physician as responsible for the care, goods, or
   services furnished by a physician’s assistant in the absence of the supervising physician.

236. 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 the AHCA to the
   contractor under terms of the contract.

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

238. Sample
   Subset of the units of a population taken and used in accordance with generally accepted statistical
   methods.

239. Screen, screening, or screening services
   Assessment of a recipient’s physical or mental condition to determine the need for further evaluation
   or services.

240. Self-audit
   Review of claims a provider conducts on its own to ensure Florida Medicaid compliance.

241. 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.
   (Also see Medicaid services and Covered services).

242. Service area
   Designated geographical area within which the contractor is authorized by contract to furnish covered
   services to health plan enrollees and within which the enrollees reside.

243. Service authorization
   Approval required from the designated authority for reimbursement for certain Florida Medicaid
   services.

244. Service limit or service limitation
   Maximum amount, duration, or scope of a Florida Medicaid-covered service.

245. Service limitation period
   Period of time that is used in the calculation and application of service limitations.

246. Service site(s)
   Location(s) designated by a contractor where enrollees receive services covered under terms of the
   contract.

247. Service utilization reports or service utilization data
   Reports indicating Florida Medicaid and other services utilized by recipients; referral reports by AHCA
   staff regarding the recipient’s utilization of his or her Medicaid ID and services locally; and referral
   reports from the Florida Medicaid Drug Utilization Review (DUR) program.

248. Simple mistake
   Inadvertent or unintentional error.

249. Solicitation
   See Bribe, kickback, or illegal solicitation.
250. **Specialty plan**
Managed care plan that renders services to Florida Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.

251. **State-defined health maintenance organization**
Entity certified by AHCA as meeting the Florida Medicaid State Plan definition of a Medicaid health maintenance organization.

252. **Statewide Medicaid Managed Care**
Created in 2011 by the Florida Legislature and made up of two different programs:
- Long-term care plans (see Long-term Care Plan).
- Managed medical assistance plans (see Managed Medical Assistance Plan).

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

254. **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.

255. **Supervision**
Directing and being fully legally responsible for the actions of another person. Direct supervision is face-to-face supervision during the time the services are being furnished. Personal supervision means that the services are furnished while the supervising practitioner is in the building and that the supervising practitioner signs and dates the medical records (chart) within 24 hours of the provision of the service.

256. **Supplies and appliances**
Items necessary for use by a patient during the course of an illness or injury.

257. **Support coordinator**
See Case manager.

258. **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.

259. **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.

260. **Target group**
Specific population identified in a state plan amendment to receive targeted case management services from providers meeting specific eligibility requirements by age, type or degree of disability, illness or condition, or any other identifiable characteristic or combination thereof.

261. **Terminal or terminally ill**
Medical prognosis, as certified by a physician, of a life expectancy of six months or less.

262. **Termination**
Exclusion by AHCA of a provider from further participation in the Florida Medicaid program for a period of more than one year up to twenty years, after which the provider must apply to AHCA for reenrollment.

263. **Third-party**
Individual, entity, or program, other than Florida Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Florida Medicaid.
264. **Third-party benefit**
Any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third-party and any person or entity, including, a Florida Medicaid recipient, a provider, another third-party, an insurer, or AHCA, for any Florida Medicaid-covered injury, illness, or other medical or allied care, goods, or services, including costs of medical or allied care, goods, or services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient, unless available under terms of the policy to pay medical expenses prior to death. The term includes, without limitation, collateral as defined in this section, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance or personal injury protection coverage, medical benefits under workers’ compensation, and any obligation under law or equity to furnish medical support.

265. **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 services.

266. **Treating provider**
Individual provider who personally renders Florida Medicaid services, or assumes responsibility for rendering Florida Medicaid services through personal supervision, on behalf of a Florida Medicaid group provider. Services furnished by a treating provider are billed by and payment is remitted to the group provider.

267. **Treatment plan**
See Active treatment plan and Plan of care.

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

269. **Treatment team**
All professional staff members involved in providing services to a recipient.

270. **Unclean claim**
Claim that has not been properly completed, according to Florida Medicaid’s billing guidelines, including a claim that is not accompanied by the necessary documentation required by state law, federal law, or state administrative rule for payment.

271. **Underutilization**
Failure by a recipient to obtain available and needed Florida Medicaid services.

272. **Urgent services**
Services needed to immediately relieve pain or distress for medical problems such as injuries, nausea, and fever; and services needed to treat infectious diseases and other similar conditions.

273. **Utilization review (UR)**
Evaluation of the appropriateness, necessity, and quality of services billed to Florida Medicaid. It also means the evaluation of the use of Florida Medicaid services by recipients, including a recipient’s need for continued stay in an institutional care facility.

274. **Utilization review committee (URC)**
Committee composed of physicians, assisted by other professional personnel, that performs the utilization review function.

275. **Utilization review contractor**
Entity that is under contract with AHCA to perform and monitor utilization review functions, which determine the appropriateness of payments for Florida Medicaid services.

276. **Vendor**
Individual or entity that engages in the business of selling care, goods, services, or commodities.
277. **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.

278. **Void**
Negation of an original payment.

279. **Waiver case management**
Process of assisting recipients gain access to needed waiver and other state plan services in addition to medical, social, educational, and other services, without regard to the funding source of the service.

280. **Waiver plan of care**
Written individual plan developed by social and health care professionals that describes the services to be furnished, and specifies frequency and type of provider to furnish each service.