

TABLE OF CONTENTS
CHAPTER TWENTY-NINE
DEFINITIONS OF TERMS USED IN RULES

Rule	Title	Page
560-X-29-.01	Definitions	1

Chapter 29 – Definitions of Terms Used in Rules

Rule No. 560-X-29-.01 Definitions

The following terms and definitions are presented as reference to accompany and clarify the rules contained in this Administrative Code of the Alabama Medicaid Agency.

(1) Abuse - shall be any act or action taken by a recipient or provider which has a detrimental effect upon the Alabama Medicaid Program and which is not provided for or anticipated under the provisions of the Alabama Medicaid Program. The following examples shall constitute prima facie evidence, though not conclusive evidence, of abuse of the Alabama Medicaid Program:

(a) Failure to make any payment due Medicaid from any third-party recovery.

(b) Having knowledge that an individual other than the authorized recipient, has used a Medicaid eligibility card to obtain benefits provided by the Alabama Medicaid Program and not reporting this unauthorized use to Medicaid within a reasonable period of time not to exceed 60 days;

(c) Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from Medicaid.

(d) Failure to repay identified over-payments or erroneous payments received from Medicaid.

(2) Actuarially Sound Rates - actuarially sound rates are rates that have been developed in accordance with generally accepted actuarial principles and practices appropriate for the populations to be covered and the services to be furnished under the contract and certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

(3) Actuary - An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board; Actuary refers to an individual who is acting on behalf of the state when used in reference to the development and certification of capitation rates.

(4) Application Assisters - Individuals trained by the Medicaid Agency to assist recipients in completing Medicaid applications.

(5) Benchmark - A benchmark is a standard by which requirements can be measured or judged.

(6) Care Coordination - Coordination of patient care services including recruitment, outreach, psychosocial assessment, service planning, assisting the Recipient in arranging for appropriate services, including but not limited to, resolving transportation issues, education,

counseling and follow-up and monitoring to ensure services are delivered and continuity of care is maintained.

(7) Capitation payment - A payment the state makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the state plan.

(8) Claim - Claim shall mean all charges included in a single billing by a single provider for one type of service rendered to one recipient. Each prescription shall be considered one claim. On group claims, such as nursing home claims, each line item covering a period of service shall be considered a claim.

(9) Chronic Stable Medical Condition – A condition that has persisted over six months and clinical documentation supports that there have been no significant changes in the past 60 days or in the 60 day period prior to admission into a Medicaid program.

(10) Dental Services - Dental services are those services for recipients under 21 years of age which are necessary for relief of pain and infection, for restoration of teeth, and for maintenance of dental health and which are authorized by Medicaid.

(11) Emergency Services - Emergency services shall mean those medical services which are necessary to prevent the death or serious impairment of the health of a recipient and which, because of the threat to the life or health of the recipient, necessitates the use of the most accessible services available and equipped to furnish such services.

(12) Emergency Room Services - Emergency room services mean those services performed in an emergency room and in response to bona fide emergencies. A patient having coverage under Medicaid is entitled to have payment made on his behalf for outpatient hospital benefits which are medically necessary. Medicaid will only authorize payment for bona fide emergency treatment rendered in hospital emergency rooms. Any service rendered other than a bona fide emergency must state the type of outpatient service, and be so billed as an outpatient services(s).

(13) Eye care Services - Eye care services for the Medicaid Program are defined as those health care services requested by eligible recipients for eye examinations (as defined herein), including refraction and prescription for eyeglasses, if necessary, performed by physicians who are trained in eye examination procedures or by licensed optometrists, and the provision of eyeglasses, frames, or lenses by a firm under contract with Medicaid. If eyeglasses are required and provided, services will include verification of prescription, dispensing of eyeglasses (including laboratory selection), frame selection, procurement of eyeglasses and fitting and adjusting eyeglasses to the patient by the above mentioned physician and optometrists or by licensed opticians

(14) Eye Examination - Eye examination is a complete eye examination, including the case history, eye health examination visual acuity testing, visual fields, if indicated, tonometry, refraction and prescribing of eye glasses, if indicated.

(15) Fraud - Any Medicaid recipient or Medicaid recipient's sponsor or provider who knowingly, with intent to defraud or deceive, make or causes to be made any false statement or representation of a material fact in any application of claim for benefits or payment under the Alabama Medicaid Program. The following examples shall be prima facie evidence, though not conclusive evidence, of fraud:

(a) A Medicaid recipient, sponsor, or provider making a false statement or representation in any application for benefits or payment for benefits to a recipient under the Alabama Medicaid Program;

(b) A Medicaid recipient obtaining, or provider rendering, any service under the Alabama Medicaid Program by making false statement of the recipient's condition or illness while knowing such statement is false;

(c) A Medicaid recipient or sponsor obtaining drugs, supplies, or any durable item provided under the Alabama Medicaid Program not for his or her own benefits but with the intent to sell the same item for a valuable consideration.

(d) A Medicaid recipient allowing his or her eligibility card to be used by someone else with the knowledge that the other individuals intends to obtain benefits provided by the Alabama Medicaid Program.

(16) Grievance - An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

(17) Grievance and appeal system - The processes the Manage Care Programs (including but not limited to MCO, PIHP, PAHP, PCCM and PCCM entities) implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information concerning the grievances and appeals.

(18) Health Maintenance Organization - An organization which provides, either directly or through contractual arrangements, health care services, medical assistance, and rehabilitative services which enrollees might reasonably require to be maintained in good health. Payment for such services shall be made on a capitation basis.

(19) Home Health Care Services - Home health care services shall mean visits ordered by a physician authorized by Medicaid and provided to home bound recipients by licensed registered and practical nurse and nurses aides from authorized home health care agencies; and medical supplies, appliances, and items or durable medical equipment suitable for use in the home.

(20) Independent Laboratory and Radiology Services - Independent laboratory and radiology services are those services ordered by a physician or dentist, in connection with

medical or dental services, and which are performed by a Medicare/Medicaid facility that operates primarily independent of a physician's office or other health care facility.

(21) Medical Supplies - Medical supplies, appliances, and equipment are those items listed in the Home Health Care Manual or specifically prior authorized for a recipient by Medicaid.

(22) Medicare - Medicare shall mean the program providing hospital and medical benefits under Title XVIII of the Social Security Act.

(23) Medicare Deductibles and Coinsurance - Medicare deductibles and coinsurance mean all charges classified as deductibles and/or coinsurance under Medicare Part A and/or Part B for all services authorized by Medicare Part A and/or Part B.

(24) Physician - Physician shall mean:

(a) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he renders services;

(b) A doctor of dentistry or of dental or oral surgery licensed to practice dentistry or dental or oral surgery by the state in which he renders services but only with respect to:

1. Surgery related to the jaw;
2. The reduction of any fracture relating to the jaw or facial bone;
3. Surgery within the oral cavity for removal of lesions or the correction of congenital defects;
4. Fabrication of a prosthesis for closure of a space within the oral cavity created by the removal of a lesion, or congenital defect such as cleft palate.

(25) Prescribed Drugs - Medicaid covers only legend and certain non-legend drugs of participating manufacturers which have entered into rebate agreements with Health and Human Services when the drugs are prescribed by licensed physicians or dentists for medically accepted conditions, and dispensed by contract Medicaid providers. Certain drugs may be excluded by federal law.

(26) Provider - Provider shall mean an institution, facility, agency, person, partnership, corporation, or association which is approved and certified by Medicaid as authorized to provide the recipients the services specified in the plan at the time services are rendered.

(27) Recipient - Recipient shall mean a person who has been assigned one or more Medicaid identification numbers and has been certified by Medicaid as eligible for medical assistance under the State Plan.

(28) Screening (Early and Periodic Screening, Diagnosis, and Treatment) - an unclotted physical examination using quick, simple procedures to sort out apparently well children from those who have a disease, condition or abnormality and to identify those who may need diagnosis, evaluation and/or treatment of their physical or mental problems. Refer to Chapter 11, EPSDT, for further information.

(29) Special Ophthalmic Services - Special ophthalmic services are orthoptics, eye examination for contact lenses following cataract surgery and such other eye care services authorized by Alabama Medicaid Agency when performed by a licensed physician (ophthalmologist) or optometrist.

(30) Misuse/Overutilization - is any act or action taken by a Medicaid recipient or provider which results in a recipient receiving services in excess of those normally required for the illness or malady suffered by the recipient and which results in unnecessary cost to the Alabama Medicaid Program. The following examples shall constitute prima facie evidence, though not conclusive evidence, of misuse of the Alabama Medicaid Program:

(a) A Medicaid recipient going to more than one doctor for treatment of the same illness when there is no justifiable medical reason for the recipient seeking services from more than one physician;

(b) A Medicaid recipient obtaining from more than one physician or from the same physician multiple prescriptions for the same drugs for the same period of consumption.

(c) A Medicaid recipient attempting to stockpile drugs by obtaining prescriptions for drugs for illnesses or conditions which the recipient is not suffering from or afflicted by;

(d) Charges by a provider in excess of reasonable and allowable costs.

(31) Network provider - Any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP.

(32) Peer - A person or committee in the same health care profession as the provider whose Medicaid practices are being reviewed.

(33) Peer Review - An activity performed by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally accepted standards.

(34) Prepaid ambulatory health plan (PAHP) - An entity that—

(a) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates.

(b) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and

(c) Does not have a comprehensive risk contract.

(35) Provider - Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

(36) Recoupment - The procedure of obtaining repayment of an equivalent overpayment received from the Medicaid program by a provider or recipient. Procedure could include withholding payments for claims being processed.

(37) REOMB - Recipient Explanation of Medical Benefits, a Medicaid Management Information System requirement for recipient to verify services received.

(38) Restitution - The procedure of reimbursement by a provider or recipient to the Medicaid program for payments and/or benefits wrongfully received.

(39) Suspension from Participation - Exclusion from participation in the Medicaid program for a specified period of time.

(40) Termination from Participation - a permanent exclusion from participation in the Medicaid program.

(41) Utilization Review - A procedure to assure that services provided are commensurate with the patient's medical conditions. This includes reviewing quality of care, medical necessity, and scope of services.

(42) Place of Residence - A patient's residence is wherever he/she makes his/her home. This may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. Hospitals, nursing homes or extended care facilities may not be considered his/her residence for purpose of home health coverage.

(43) Subcontractor - An individual or entity that has a contract with a MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the state. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP.

(44) Unstable Medical Condition – One in which there is documentation of an episode of acute illness or exacerbation of a diagnosis which requires active treatment in the 60 days prior to the admission date into a Medicaid program. The provider must have supporting documentation of the acute illness or exacerbation and active treatment.

(45) Withholding of Payments - A reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purpose of offsetting overpayments previously made to the provider.

Author: Jerri R. Jackson, Director, Managed Care Division.

Statutory Authority: State Plan; 42 CFR Section 401, et seq.

History: Rule effective October 1, 1982. Effective date of this amendment is May 13, 1992.

Amended: Filed November 17, 2006; effective February 15, 2007. **Repealed and New Rule:** Filed September 11, 2018; effective October 26, 2018.