

Glossary

Appeal: A grievance process for resolving disputes. A beneficiary/ representative may request and obtain an Administrative Appeal of an HSM denial determination that was upheld or modified through HSM'S reconsideration process.

Beneficiary: An individual eligible for medical assistance in accordance with state's Medicaid Program and who has been certified as eligible by the appropriate agency and has received services.

Certification: Authorization of services by HSM for Medicaid covered services.

Concurrent Certification Reviews: A review that is performed after the initial review and during a beneficiary's treatment to determine the medical necessity and appropriateness of continuing the beneficiary's treatment.

Comprehensive Evaluation: Before therapy is initiated, an evaluation of the beneficiary's medical condition, disability and level of functioning must be performed to determine the need for treatment. When a need for treatment is determined, a treatment plan must be developed.

Criteria: Predetermined elements of health care, developed by health professionals relying on professional expertise, prior experience, and the professional literature, with which aspects of the quality, medical necessity, and appropriateness of a health care service may be compared.

Denial Determination: A negative decision by a professional review organization, regarding the medical necessity, quality, or appropriateness of health care services furnished, or proposed to be furnished to a beneficiary.

Modification: Any limit or change to a certification request.

Pend: Status assigned to a review request by HSM when additional information necessary to complete the review process is required. HSM informs the provider of the need for the information and allows a specific timeframe for submission.

Plan of Care: A written plan describing the treatment proposed for each Medicaid beneficiary.

Precertification: Authorization of services by HSM prior to the date and or time the services are to begin.

Provider: Person, entity, or facility enrolled in the Medicaid program, renders services to Medicaid beneficiaries, and bills Medicaid for services.

Quality Assurance Review: An assessment of patient care conducted by HSM for the purpose of improving patient care through peer analysis, intervention, resolution of the problem and follow-up.

Quality Re-review – due process offered to providers when there is disagreement with any confirmed quality issue identified by HSM.

Reconsideration: The review of an adverse determination previously rendered by HSM, requested by a provider or beneficiary/representative.

Retrospective Review: A review that is conducted after services are provided to a beneficiary. The review is focused on determining the appropriateness, medical necessity, quality of care, and reasonableness of healthcare services provided.

Same Day/Non-Urgent: The delivery of therapy services that do not meet the definition of urgent, but completion of services on the same day as the evaluation significantly impacts the beneficiary's treatment (example: therapeutic activities, such as the use of crutches, on the same day as diagnosis/treatment of leg fracture).

Severity Level – all confirmed problems are assigned a severity level according to the significant adverse effect to the patient. There are 3 levels:

- **Level I** – a confirmed quality problem with minimal potential for significant adverse effect to the patient.
- **Level II** – a confirmed quality problem with the potential for significant adverse effect to the patient.
- **Level III** – a confirmed quality problem with significant adverse effect to the patient.

Significant Adverse Effect – unnecessarily prolonged treatment, complications, readmissions, or patient management that results in anatomical or physiological impairment, disability, or death.

Source of Problem – a provider deemed responsible for a confirmed quality problem (i.e., therapist, physician, physician assistant, nurse practitioner, outpatient facility)

Suspend: Act of discontinuation of certification review of a request for services because additional information was not received by HSM in the timeframe allocated.

Technical Denial: A denial issued when no medical record or insufficient information to make a determination is provided for review.

Treatment Authorization Number (TAN): Approval number that the provider uses to seek payment from the fiscal agent.

Urgent Care: The delivery of therapy services resulting from the sudden onset of a medical condition or injury requiring immediate care and manifesting itself by acute symptoms of sufficient severity such that the absence of therapy could result in immediate: hospitalization, moderate impairment to bodily function, serious dysfunction of any bodily organ or part or other serious medical consequences.