Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers**

DATE: **August 1, 2006**

SUBJECT: **Provider Manual Update Transmittal**

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REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
400.000	10-13-03	400.000	8-1-06

Explanation of Updates

Section IV has been updated to reflect changes in agency names, acronyms and definitions. Information no longer applicable has been deleted.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8091. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

SECTION IV - GLOSSARY

400.000 **8-1-06**

AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ABESPA	Arkansas Board of Examiners in Speech-Language Pathology and Audiology
ACD	Augmentative Communication Device
ACIP	Advisory Committee on Immunization Practices
ACES	Arkansas Client Eligibility System
ACS	Alternative Community Services
ADE	Arkansas Department of Education
ADH	Arkansas Department of Health (renamed Division of Health)
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children (cash assistance program replaced by the Transitional Employment Assistance (TEA) assistance program)
AFMC	Arkansas Foundation for Medical Care, Inc.
AHEC	Area Health Education Centers
ALF	Assisted Living Facilities
ALS	Advance Life Support
ALTE	Apparent Life Threatening Events
AMA	American Medical Association
APD	Adults with Physical Disabilities
ARS	Arkansas Rehabilitation Services
ASC	Ambulatory Surgical Centers
ASHA	American Speech-Language-Hearing Association
BIPA	Benefits Improvement and Protection Act
BLS	Basic Life Support
CARF	Commission on Accreditation of Rehabilitation Facilities
CCRC	Children's Case Review Committee
CFA	One Counseling and Fiscal Agent
CFR	Code of Federal Regulations
CHMS	Child Health Management Services
CLIA	Clinical Laboratory Improvement Amendments
CME	Continuing Medical Education
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COA	Council on Accreditation
CON	Certification of Need

CPT	Physicians' Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CSHCN	Children with Special Health Care Needs
CSWE	Council on Social Work Education
D&E	Diagnosis and Evaluation
DAAS	Division of Aging and Adult Services
DBS	Division of Blind Services (currently named Division of Services for the Blind)
DCFS	Division of Children and Family Services
DCO	Division of County Operations
DD	Developmentally Disabled
DDS	Developmental Disabilities Services
DDTCS	Developmental Day Treatment Clinic Services
DH	Division of Health (formerly Arkansas Department of Health)
DHS	Department of Human Services (renamed Department of Health and Human Services)
DHHS	Department of Health and Human Services (formerly Department of Human Services)
DLS	Daily Living Skills
DME	Durable Medical Equipment
DMHS	Division of Mental Health Services
DMS	Division of Medical Services (Medicaid)
DOS	Date of Service
DRG	Diagnosis Related Group
DRS	Developmental Rehabilitative Services
DSB	Division of Services for the Blind (formerly Division of Blind Services)
DSH	Disproportionate Share Hospital
DURC	Drug Utilization Review Committees
DYS	Division of Youth Services
EAC	Estimated Acquisition Cost
EDS	Electronic Data Systems
EFT	Electronic Funds Transfer
EIN	Employer Identification Number
EOB	Explanation of Benefits
EOMB	Explanation of Medicaid Benefits. EOMB may also refer to Explanation of Medicare Benefits.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ESC	Education Services Cooperative
FEIN	Federal Employee Identification Number

FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
GUL	Generic Upper Limit
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System
HDC	Human Development Center
HHS	The Federal Department of Health and Human Services
HIC Number	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
IADL	Instrumental Activities of Daily Living
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification
ICF/MR	Intermediate Care Facility/ Mental Retardation
ICN	Internal Control Number
IDEA	Individuals with Disabilities Education Act
IDG	Interdisciplinary Group
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IMD	Institution for Mental Diseases
IPP	Individual Program Plan
IUD	Intrauterine Devices
JCAHO	Joint Commission on Accreditation of Healthcare Organization
LAC	Licensed Associate Counselor
LCSW	Licensed Certified Social Worker
LEA	Local Education Agencies
LMFT	Licensed Marriage and Family Therapist
LMHP	Licensed Mental Health Practitioner
LPC	Licensed Professional Counselor
LPE	Licensed Psychological Examiner
LSPS	Licensed School Psychology Specialist
LTC	Long Term Care
MAC	Maximum Allowable Cost
MAPS	Multi-agency Pan of Services
MART	Medicaid Agency Review Team
MEI	Medicare Economic Index
MMIS	Medicaid Management Information System
MNIL	Medically Needy Income Limit

MPPPP	Medicaid Prudent Pharmaceutical Purchasing Program
MSA	Metropolitan Statistical Area
MUMP	Medicaid Utilization Management Program
NBCOT	National Board for Certification of Occupational Therapy
NCATE	North Central Accreditation for Teacher Education
NDC	National Drug Code
NET	Non-Emergency Transportation Services
NF	Nursing Facility
OBRA	Omnibus Budget Reconciliation Act
OHCDS	Organized Health Care Delivery System
OTC	Over the Counter
PA	Prior Authorization
PAC	Provider Assistance Center
PCP	Primary Care Physician
PERS	Personal Emergency Response Systems
PES	Provider Electronic Solutions
PHS	Public Health Services
PIM	Provider Information Memorandum
PL	Public Law
POC	Plan of Care
POS	Place of Service
PPS	Prospective Payment System
PRN	Pro Re Nata or “As Needed”
PRO	Professional Review Organization
ProDUR	Prospective Drug Utilization Review
QMB	Qualified Medicare Beneficiary
QMRP	Qualified Mental Retardation Professional
RA	Remittance Advice. Also called Remittance and Status Report.
RFP	Request for Proposal
RHC	Rural Health Clinic
RID	Recipient Identification Number
RSPD	Rehabilitative Services for Persons with Physical Disabilities
RSPMI	Rehabilitation Services for Persons with Mental Illness
RSYC	Rehabilitative Services for Youth and Children
RTC	Residential Treatment Centers
RTP	Return to Provider
RTU	Residential Treatment Units
SBMH	School Based Mental Health Services

SD	Spend Down
SFY	State Fiscal Year
SMB	Special Low Income Qualified Medicare Beneficiaries
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SURS	Surveillance and Utilization Review Subsystem
TCM	Targeted Case Management
TEA	Transitional Employment Assistance
TEFRA	Tax Equity and Fiscal Responsibility Act
TOS	Type of Service
TPL	Third Party Liability
UPL	Upper Payment Limit
UR	Utilization Review
VFC	Vaccines for Children
VRS	Voice Response System
Accommodation	A type of hospital room, e.g., private, semiprivate, ward, etc.
Activities of Daily Living (ADL)	Personal tasks which are ordinarily performed on a daily basis and include eating, mobility/transfer, dressing, bathing, toileting and grooming.
Adjudicate	To determine whether a claim is to be paid or denied.
Adjustments	Transactions to correct claims paid in error or to adjust payments from a retroactive change.
Admission	Actual entry and continuous stay of the recipient as an inpatient to an institutional facility.
Affiliates	Persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.
Agency	The Division of Medical Services.
Aid Category	A designation within SSI or state regulations under which a person may be eligible for public assistance.
Aid to Families with Dependent Children (AFDC)	A Medicaid eligibility category.
Allowed Amount	The maximum amount Medicaid will pay for a service as billed before applying recipient coinsurance or copay, previous TPL payment, spend down liability or other deducted charges.
American Medical Association (AMA)	National association of physicians.
Ancillary Services	Services available to a patient other than room and board. For example: pharmacy, X-ray, lab and central supplies.
Arkansas Client Eligibility System (ACES)	A state computer system in which data is entered to update assistance eligibility information and recipient files.

Arkansas Foundation for Medical Care, Inc. (AFMC)	State professional review organization.
Attending Physician	See Performing Physician.
Automated Eligibility Verification Claims Submission (AEVCS)	On-line system for providers to verify eligibility of recipients and submit claims to fiscal agent.
Base Charge	A set amount allowed for a participating provider according to specialty.
Beneficiary	Person who meets the Medicaid eligibility requirements, receives an ID card and is eligible for Medicaid services. (formerly recipient)
Benefits	Services available under the Arkansas Medicaid Program.
Billed Amount	The amount billed to Medicaid for a rendered service.
Buy-In	A process whereby the state enters into an agreement with the Bureau of Health Insurance, Social Security Administration, to obtain Medicare Part B (and part A when needed) for Medicaid beneficiaries who are also eligible for Medicare. The state pays the monthly Medicare premium(s) on behalf of the beneficiary.
Care Plan	See Plan of Care (POC)
Casehead	An adult responsible for an AFDC or Medicaid child.
Categorically Needy	All individuals receiving financial assistance under the state's approved plan under Title I, IV-A, X, XIV and XVI of the Social Security Act or in need under the state's standards for financial eligibility in such a plan.
Centers for Medicare and Medicaid Services	Federal agency that administers federal Medicaid funding.
Child Health Services	Arkansas Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.
Children's Medical Services (CMS)	A Title V Children with Special Health Care Needs Program administered by the Arkansas Division of Developmental Disabilities Services to provide medical care and service coordination to chronically and disabled children.
Claim	A request for payment for services rendered.
Claim Detail	See Line Item.
Clinic	(1) A facility for diagnosis and treatment of outpatients. (2) A group practice in which several physicians work together.
Closed-end Provider Agreement	An agreement for a specific period of time not to exceed 12 months which must be renewed in order for the provider to continue to participate in the Title XIX Program.
Coinsurance	The portion of allowed charges the patient is responsible for under Medicare. This may be covered by other insurance such as Medi-Pak or Medicaid (if entitled). This also refers to the portion of a Medicaid covered inpatient hospital stay for which the beneficiary is responsible.
Contract	Written agreement between a provider of medical services and the Arkansas Division of Medical Services. A contract must be signed by each provider of services participating in the Medicaid Program.

Co-pay	The portion of the maximum allowable (either that of Medicaid or a third-party payer) that the insured or beneficiary must pay.
Cosmetic Surgery	Any surgical procedure directed at improving appearance but not medically necessary.
Covered Service	Service which is within the scope of the Arkansas Medicaid Program.
Current Procedural Terminology	A listing published annually by AMA consisting of current medical terms and the corresponding procedure codes used for reporting medical services and procedures performed by physicians.
Credit Claim	A claim transaction which has a negative effect on a previously processed claim.
Crossover Claim	A claim for which both Titles XVIII (Medicare) and XIX (Medicaid) are liable for services rendered to a beneficiary entitled to benefits under both programs.
Date of Service	Date or dates on which a beneficiary receives a covered service. Documentation of services and units received must be in the beneficiary's record for each date of service.
Deductible	The amount the Medicare beneficiary must pay toward covered benefits before Medicare or insurance payment can be made for additional benefits. Medicare Part A and Part B deductibles are paid by Medicaid within the program limits.
Debit Claim	A claim transaction which has a positive effect on a previously processed claim.
Denial	A claim for which payment is disallowed.
Department of Health and Human Services (HHS)	Federal health and human services agency.
Department of Health and Human Services (DHHS)	State health and human services agency. (formerly Department of Human Services)
Dependent	A spouse or child of the individual who is entitled to benefits under the Medicaid Program.
Diagnosis	The identity of a condition, cause or disease.
Diagnostic Admission	Admission to a hospital primarily for the purpose of diagnosis.
Disallow	To subtract a portion of a billed charge that exceeds the Medicaid maximum or to deny an entire charge because Medicaid pays Medicare Part A and B deductibles subject to program limitations for eligible beneficiaries.
Discounts	A discount is defined as the lowest available price charged by a provider to a client or third party payer, including any discount, for a specific service during a specific period by an individual provider. If a Medicaid provider offers a professional or volume discount to any customer, claims submitted to Medicaid must reflect the same discount. Example: If a laboratory provider charges a private physician or clinic a discounted rate for services, the charge submitted to Medicaid for the same service must not exceed the discounted price charged to the physician or clinic. Medicaid must be given the benefit of discounts and price concessions the lab gives any one of its customers.

Duplicate Claim	A claim that has been submitted or paid previously or a claim that is identical to a claim in process.
Durable Medical Equipment	Equipment that (1) can withstand repeated use and (2) is used to serve a medical purpose. Examples include a wheelchair or hospital bed.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally mandated Medicaid program for eligible individuals under the age of 21. See Child Health Services.
Electronic Data Systems Corporation (EDS)	Current fiscal agent for the state Medicaid program.
Eligible	(1) To be qualified for Medicaid benefits. (2) One who is qualified for benefits.
Eligibility File	A file containing individual records for all persons who are eligible or have been eligible for Medicaid.
Emergency Services	Inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services. Source: 42 U.S. Code of Federal Regulations (42 CFR) and §424.101.
Error Code	A numeric code indicating the type of error found in processing a claim. Also known as an "Explanation of Benefits (EOB) code" or a "HIPAA Explanation of Benefits (HEOB) code."
Estimated Acquisition Cost	The estimated amount a pharmacy actually pays to obtain a drug.
Experimental Surgery	Any surgical procedure considered experimental in nature.
Explanation of Medicaid Benefits (EOMB)	A statement mailed once per month to selected beneficiaries to allow them to confirm the Medicaid service which they received.
Family Planning Services	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician, nurse practitioner, certified nurse-midwife, pharmacy, hospital, family planning clinic, rural health clinic (RHC), Federally Qualified Health Center (FQHC) or the Division of Health to individuals of child-bearing age for purposes of enabling such individuals freedom to determine the number and spacing of their children.
Field Audit	An activity performed whereby a provider's facilities, procedures, records and books are audited for compliance with Medicaid regulations and standards. A field audit may be conducted on a routine basis, or on a special basis announced or unannounced.
Fiscal Agent	An organization authorized by the State of Arkansas to process Medicaid claims.
Fiscal Agent Intermediary	A private business firm which has entered into a contract with the Arkansas Department of Health and Human Services to process Medicaid claims.
Fiscal Year	The twelve-month period between settlements of financial accounts.

Generic Upper Limit (GUL)	The maximum drug cost that may be used to compute reimbursement for specified multiple-source drugs unless the provisions for a Generic Upper Limit override have been met. The Generic Upper Limit may be established or revised by the Centers for Medicare and Medicaid Services (CMS) or by the State Medicaid Agency.
Group Practice	A medical practice in which several practitioners render and bill for services under a single provider number.
Healthcare Common Procedure Coding System (HCPCS)	Federally defined procedure codes.
Health Insurance Claim Number	Number assigned to Medicare beneficiaries and individuals eligible for SSI.
Hospital	An institution that meets the following qualifications: • Provides diagnostic and rehabilitation services to inpatients. • Maintains clinical records on all patients. • Has by-laws with respect to its staff of physicians. • Requires each patient to be under the care of a physician, dentist or certified nurse-midwife. • Provides 24-hour nursing service. • Has a hospital utilization review plan in effect. • Is licensed by the State. • Meets other health and safety requirements set by the Secretary of Health and Human Services.
Hospital-Based Physician	A physician who is a hospital employee and is paid for services by the hospital.
ID Card	An identification card issued to Medicaid beneficiaries and ARKids First-B participants containing encoded data that permits a provider to access the card-holder's eligibility information.
Inpatient	A patient admitted to a hospital or skilled nursing facility who occupies a bed and receives inpatient services.
In-Process Claim (Pending Claim)	A claim that suspends during system processing for suspected error conditions such as: all processing requirements appear not to be met. These conditions must be reviewed by EDS or DMS and resolved before processing of the claim can be completed. (See suspended claim.)
Inquiry	A request for information.
Institutional Care	Care in an authorized private, non-profit, public or state institution or facility. Such facilities include schools for the deaf, and/or blind and institutions for the handicapped.
Instrumental Activities of Daily Living (IADL)	Tasks which are ordinarily performed on a daily or weekly basis and include meal preparation, housework, laundry, shopping, taking medications and travel/transportation.
Intensive Care	Isolated and constant observation care to patients critically ill or injured.

Interim Billing	A claim for less than the full length of an inpatient hospital stay. Also, a claim that is billed for services provided to a particular date even though services continue beyond that date. It may or may not be the final bill for a particular beneficiary's services.
Internal Control Number (ICN)	The unique 13 digit claim number that appears on a Remittance Advice.
International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9CM)	A diagnosis coding system used by medical providers to identify a patient's diagnosis and/or diagnoses on medical records and claims.
Investigational Product	Any product that is considered investigational or experimental and that is not approved by the Food and Drug Administration. The Arkansas Medicaid Program does not cover investigational products.
Julian Date	Chronological date of the year, 001 through 365 or 366, preceded on a claims number (ICN) by a two (2) digit year designation. Claim number example: 03231 (August 19, 2003).
Length Of Stay	Period of time a patient is in the hospital. Also, the number of days covered by Medicaid within a single inpatient stay.
Line Item	A service provided to a beneficiary. A claim may be made up of one or more line items for the same beneficiary. Also called a claim detail.
Long Term Care (LTC)	An office within the Arkansas Division of Medical Services responsible for nursing facilities.
Long Term Care Facility	A nursing facility.
Maximum Allowable Cost (MAC)	The maximum drug cost which may be reimbursed for specified multi-source drugs. This term is interchangeable with generic upper limit.
Medicaid Management Information System (MMIS)	The automated system utilized to process Medicaid claims.
Medical Assistance Section	A section within the Arkansas Division of Medical Services responsible for administering the Arkansas Medical Assistance Program.
Medically Needy	Individuals whose income and resources exceed the levels for assistance established under a state or federal plan for categorically needy, but are insufficient to meet costs of health and medical services.

Medical Necessity	All Medicaid benefits are based upon medical necessity. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or (where appropriate) no treatment at all. The determination of medical necessity may be made by the Medical Director for the Medicaid Program or by the Medicaid Program Quality Improvement Organization (QIO). Coverage may be denied if a service is not medically necessary accordance with the preceding criteria or is generally regarded by the medical profession as experimental inappropriate or ineffective using unless objective clinical evidence demonstrates circumstances making the service necessary.
Mis-Utilization	Any usage of the Medicaid Program by any of its providers and/or beneficiaries which is not in conformance with both State and Federal regulations and laws (includes fraud, abuse and defects in level and quality of care).
National Drug Code	The unique eleven digit number assigned to drugs which identifies the manufacturer, drug, strength and package size of each drug.
Non-Covered Services	Services not medically necessary, services provided for the personal convenience of the patient or services not covered under the Medicaid Program.
Nonpatient	An individual who receives services, such as laboratory tests, performed by a hospital, but who is not a patient of the hospital.
Nurse Practitioner	A professional nurse with credentials that meet the requirements for licensure as a nurse practitioner in the State of Arkansas.
Outpatient	A patient receiving medical services, but not admitted as an inpatient to a hospital.
Over-Utilization	Any over usage of the Medicaid Program by any of its providers and/or beneficiaries not in conformance with professional judgment and both State and Federal regulations and laws (includes fraud and abuse).
Participant	A provider of services who: (1) provides the service, (2) submits the claim and (3) accepts Medicaid's reimbursement for the services provided as payment in full.
Patient	A person under the treatment or careof a physician or surgeon, or in a hospital.
Payment	Reimbursement to the provider of services for rendering a Medicaid covered benefit.
Pay to Provider	A person, organization or institution authorized to receive payment for services provided to Medicaid beneficiaries by a person or persons who are a part of the entity.
Pay to Provider Number	A 9-digit number assigned to each Pay to Provider. Medicaid reports provider payments to the Internal Revenue Service under the Employer Identification Number "Tax ID" linked in the Medicaid Provider File to the pay to provider number.
Per Diem	A daily rate paid to institutional providers.

Performing Physician	The physician providing, supervising, or both, a medical service and claiming primary responsibility for ensuring that services are delivered as billed.
Person	Any natural person, company, firm, association, corporation or other legal entity.
Place of Service (POS)	An alpha or numeric code denoting the location of the patient receiving services.
Plan of Care	A document utilized by a provider to plan, direct or deliver care to a patient to meet specific measurable goals. Also called care plan, service plan or treatment plan.
Postpayment Utilization Review	The review of services, documentation and practice after payment.
Practitioner	An individual who practices in a health or medical service profession.
Prepayment Utilization Review	The review of services, documentation and practice patterns before payment.
Prescription	A health care professional's legal order for a drug which, in accordance with federal and/or state statutes, may not be obtained otherwise. Also an order for a particular Medicaid covered service.
Prescription Drug (RX)	A drug which, in accordance with federal and/or state statutes, may not be obtained without a valid prescription.
Primary Care Physician (PCP)	A physician responsible for the management of a beneficiary's total medical care. Selected by the beneficiary to provide primary care services and health education. The PCP will monitor on an ongoing basis the beneficiary's condition, health care needs and service delivery be responsible for locating, coordinating and monitoring medical and rehabilitation services on behalf of the beneficiary and refer the beneficiary for most specialty services, hospital care and other services.
Prior Approval	The approval for coverage and reimbursement of specific services prior to furnishing services for a specified beneficiary of Medicaid. The request for prior approval must be made to the Medical Director of the Division of Medical Services for review of required documentation and justification for provision of service.
Prior Authorization (PA)	The approval by the Arkansas Division of Medical Services or a designee of the Division of Medical Services, for specified services for a specified beneficiary to a specified provider before the requested services may be performed and before payment will be made.
Procedure Code	A five-digit numeric or alpha numeric code to identify medical services and procedures on medical claims.
Professional Component	A physician's interpretation or supervision and interpretation of laboratory, X-ray or machine test procedures.
Profile	A detailed view of an individual provider's charges to Medicaid for health care services or a detailed view of a beneficiary's usage of health care services.
Provider	A person, organization or institution enrolled to provide and be reimbursed for health or medical care services authorized under the State Title XIX Medicaid Program.
Provider Number	A nine-character code assigned to each provider of services in the Arkansas Medicaid Program for identification purposes.

Provider Relations	The activity within the Medicaid Program which handles all relationships with Medicaid providers.
Quality Assurance	Determination of quality and appropriateness of services rendered.
Quality Improvement Organization	A Quality Improvement Organization (QIO) is a federally mandated review organization required of each state's Title XIX (Medicaid) program. Arkansas Medicaid has contracted with the Arkansas Foundation for Medical Care, Inc. (AFMC) to be its QIO. The QIO monitors hospital and physician services billed to the state's Medicare intermediary and the Medicaid program to assure high quality, medical necessity and appropriate care for each patient's needs.
Railroad Claim Number	The number issued by the Railroad Retirement Board to control payments of annuities and pensions under the Railroad Retirement Act. The claim number begins with a one to three letter alphabetic prefix denoting the type of payment, followed by six or nine numeric digits.
Recipient	Person who meets the Medicaid eligibility requirements, receives an ID card and is eligible for Medicaid services. (renamed beneficiary)
Referral	An authorization from a Medicaid enrolled provider to a second Medicaid enrolled provider. The receiving provider is expected to exercise independent professional judgment and discretion, to the extent permitted by laws and rules governing the practice of the receiving practitioner, and develops and delivers medically necessary services covered by the Medicaid program. The provider making the referral may be a physician or another qualified practitioner acting within the scope of practice permitted by laws or rules. Medicaid requires documentation of the referral in the beneficiary's medical record, regardless of the means the referring provider makes the referral. Medicaid requires the receiving provider to document the referral also, and to correspond with the referring provider regarding the case when appropriate and when the referring provider so requests.
Reimbursement	The amount of money remitted to a provider.
Rejected Claim	A claim for which payment is refused.
Relative Value	A weighting scale used to relate the worth of one surgical procedure to any other. This evaluation, expressed in units, is based upon the skill, time and the experience of the physician in its performance.
Remittance	A remittance advice.
Remittance Advice (RA)	A notice sent to providers advising the status of claims received, including paid, denied, in-process and adjusted claims. It includes year-to-date payment summaries and other financial information.
Reported Charge	The total amount submitted in a claim detail by a provider of services for reimbursement.
Retroactive Medicaid Eligibility	Medicaid eligibility which may begin up to three (3) months prior to the date of application provided all eligibility factors are met in those months.
Returned Claim	A claim which is returned by the Medicaid Program to the provider for correction or change to allow it to be processed properly.
Sanction	Any corrective action taken against a provider.
Screening	The use of quick, simple medical procedures carried out among large groups of people to sort out apparently well persons from those who may have a disease or abnormality and to identify those in need of more definitive examination or treatment.

Signature	Signature or initials means the person's original signature, or the person's signature or initials may be recorded by an electronic or digital method executed or adopted by the person with the intent to be bound by or to authenticate a record. An electronic signature must comply with Arkansas Code Annotated § 25-31-101-105, including verification through an electronic signature verification company and data links invalidating the electronic signature if the data is changed.
Single State Agency	The state agency authorized to administer or supervise the administration of the Medicaid Program on a statewide basis.
Skilled Nursing Facility (SNF)	A nursing home, or a distinct part of a facility, licensed by the Office of Long Term Care as meeting the Skilled Nursing Facility Federal/State licensure and certification regulations. A health facility which provides skilled nursing care and supportive care on a 24-hour basis to residents whose primary need is for availability of skilled nursing care on an extended basis.
Social Security Administration (SSA)	A federal agency which makes disability and blindness determinations for the Secretary of the HHS.
Social Security Claim Number	The account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is the Social Security Account Number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (e.g., wife, widow, child, etc.).
Source of Care	A hospital, clinic, physician or other facility which provides services to a beneficiary under the Medicaid Program.
Specialty	The specialized area of practice of a physician or dentist.
Spend Down (SD)	The amount of money a recipient must pay toward medical expenses when income exceeds the Medicaid financial guidelines. A component of the medically needy program allows an individual or family whose income is over the medically needy income limit (MNIL) to use medical bills to spend excess income down to the MNIL. The individual(s) will have a spend down liability. The spend down column of the remittance advice indicates the amount which the provider may bill the recipient. The spend down liability occurs only on the first day of Medicaid eligibility.
Status Report	A remittance advice.
Supplemental Security Income (SSI)	A program administered by the Social Security Administration. This program replaced previous state administered programs for aged, blind or disabled beneficiaries (except in Guam, Puerto Rico and the Virgin Islands). This term may also refer to the Bureau of Supplemental Security Income within SSA which administers the program.
Suspended Claim	An "In-Process Claim" which must be reviewed and resolved.
Suspension from Participation	An exclusion from participation for a specified period of time.
Suspension of Payments	The withholding of all payments due to a provider until the resolution of a matter in dispute between the provider and the state agency.
Termination from Participation	A permanent exclusion from participation in the Title XIX Program.
Third Party Liability (TPL)	A condition whereby a person or an organization, other than the beneficiary or the state agency, is responsible for all or some portion of the costs for health or medical services incurred by the Medicaid beneficiary (e.g., a health insurance company, a casualty insurance company or another person in the case of an accident, etc.).

Utilization Review (UR)	The section of the Arkansas Division of Medical Services which performs the monitoring and controlling of the quantity and quality of health care services delivered under the Medicaid Program.
Void	A transaction which deletes.
Voice Response System (VRS)	Voice activated system to request prior authorization for prescription drugs and for PCP assignment and change.
Ward	An accommodation of five or more beds.
Withholding of Payments	A reduction or adjustment of the amounts paid to a provider on pending and subsequently due payments.
Worker's Compensation	A type of Third-Party Liability for medical services rendered as the result of an on-the-job accident or injury to a beneficiary for which the employer's insurance company may be obligated under the Worker's Compensation Act.