SECTION IV - GLOSSARY

400.000 67-1-220

AAFP	American Academy of Family Physicians
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ABESPA	Arkansas Board of Examiners in Speech-Language Pathology and Audiology
ABHSCI	Adult Behavioral Health Services for Community Independence
ACD	Augmentative Communication Device
ACIP	Advisory Committee on Immunization Practices
ACES	Arkansas Client Eligibility System
ACS	Alternative Community Services
ADDT	Adult Developmental Day Treatment
ADE	Arkansas Department of Education
ADH	Arkansas Department of Health
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children (cash assistance program replaced by the Transitional Employment Assistance (TEA) program)
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
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
DHS	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
DPSQA	Division of Provider Services and Quality Assurance
DRG	Diagnosis Related Group
DRS	Developmental Rehabilitative Services
DDSCES	Developmental Disabilities Services Community and Employment Support
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
EIDT	Early Intervention Day Treatment
EAC	Estimated Acquisition Cost
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	International Classification of Diseases
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
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
LPC	Licensed Professional Counselor
LPE	Licensed Psychological Examiner
LSPS	Licensed School Psychology Specialist
LTC	Long Term Care
MAC	Maximum Allowable Cost
MAPS	Multi-agency Plan 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
NPI	National Provider Identifier
OBRA	Omnibus Budget Reconciliation Act
OHCDS	Organized Health Care Delivery System
OBHS	Outpatient Behavioral Health Services
OTC	Over the Counter
PA	Prior Authorization
PAC	Provider Assistance Center
PASSE	Provider-led Arkansas Shared Savings Entity Program
PCP	Primary Care Physician
PERS	Personal Emergency Response Systems
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
QIDP	Qualified Intellectual Disabilities Professional
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice. Also called Remittance and Status Report
RFP	Request for Proposal
RHC	Rural Health Clinic
BID	Beneficiary Identification Number
RSPD	Rehabilitative Services for Persons with Physical Disabilities
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 that are ordinarily performed daily 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 beneficiary as an inpatient to an institutional facility
Affiliates	Persons having an overt or covert relationship such that any individual directly or indirectly controls or has the power to control another individual
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 beneficiary coinsurance or co-pay, 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 beneficiary files
Attending Physician	*See Performing Physician*.
Automated Eligibility Verification Claims Submission (AEVCS)	Online system for providers to verify eligibility of beneficiaries 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 Medicaid/Medicare and the 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.
Caregiver	An individual who has responsibility for the protection, in-home care, or custody of a Medicaid enrollee as a result of assuming the responsibility by contract.
Care Plan	*See Plan of Care (POC).*
Case Head	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 with Chronic Health Conditions (CHC)	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 children with chronic physical illnesses or disabilities.
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
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 reimbursement of services provided 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 Human Services (DHS)	State human services agency
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 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 twenty-one (21). *See Child Health Services*.

Education Accreditation	When an individual is required to possess a bachelor's degree, master's degree, or a Ph.D. degree in a specific profession. The degree must be from a program accredited by an organization that is approved by the Council for Higher Education Accreditation (CHEA).
Electronic Signature	An electronic or digital method executed or adopted by a party with the intent to be bound by or to authenticate a record, which is: (a) Unique to the person using it; (b) Capable of verification; (c) Under the sole control of the person using it; and (d) Linked to data in such a manner that if the data are changed the electronic signature is invalidated. An Electronic Signature method must be approved by the DHS Chief Information Officer or his or her designee before it will be accepted. A list of approved electronic signature methods will be posted on the state Medicaid website.
Eligible	(1) To be qualified for Medicaid benefits. (2) An individual 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 Department 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 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	Two (2) or more persons. If a service is a "group" therapy or other group service, there must be two (2) or more persons present and receiving the service.
Group Practice	A medical practice in which several practitioners render and bill for services under a single pay-to provider identification 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
Individual	A single person as distinguished from a group. If a service is an "individual" therapy or service, there may be only one (1) person present who is receiving the service.
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 the Arkansas Medicaid fiscal agent 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, or blind and institutions for individuals with disabilities.
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	A diagnosis coding system used by medical providers to identify a patient's diagnosis 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-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.
Limited Services Provider Agreement	An agreement for a specific period of time not to exceed twelve (12) months, which must be renewed in order for the provider to continue to participate in the Title XIX Program.
Line Item	A service provided to a beneficiary. A claim may be made up of one (1) 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 Provider Number	A unique identifying number assigned to each provider of services in the Arkansas Medicaid Program, required for identification purposes
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 in 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 or beneficiaries which is not in conformance with both State and Federal regulations and laws (including, but not limited to, fraud, abuse, and defects in level and quality of care)
National Drug Code	The unique 11-digit number assigned to drugs which identifies the manufacturer, drug, strength, and package size of each drug
National Provider Identifier (NPI)	A standardized unique health identifier for health care providers for use in the health care system in connection with standard transactions for all covered entities. Established by the Centers for Medicare & Medicaid Services, HHS, in compliance with HIPAA Administrative Simplification – 45 CFR Part 162.
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 or beneficiaries not in conformance with professional judgment and both State and Federal regulations and laws (including, but not limited to, 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 care of 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 unique identifying number assigned to each pay-to provider of services (Clinic/Group/Facility) in the Arkansas Medicaid Program or the pay-to provider group's assigned National Provider Identifier (NPI). 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 identification 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)	A nationally approved two-digit 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 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 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. **Prior authorization does not guarantee reimbursement.**
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 Identification Number	A unique identifying number assigned to each provider of services in the Arkansas Medicaid Program or the provider's assigned National Provider Identifier (NPI), when applicable, that is required 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. 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 (6) or nine (9) numeric digits.
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 to develop and deliver 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.
Registry records check	The review of one (1) or more database systems maintained by a state agency that contain information relative to the suitability of a person to be a caregiver.
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 (1) 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	The person's original signature or initials. The person's signature or initials may also 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 (3) 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 beneficiary 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 beneficiary. 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 individuals with disabilities (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

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 (5) 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

TOC NOT REQUIRED

260.420 Employer Authority 61-1-2219

The IndependentChoices participant is the employer of record, and as such, hires a ~~Personal Assistant~~Caregiver ~~who meets~~meeting these requirements:

A. Is a US citizen or legally authorized ~~alien with approval~~ to work in the US;

B. Has a valid Social Security number;

C. Signs a Work Agreement with the participant/Representative;

D. Must be able to provide references if requested;

E. Must successfully pass a criminal background check:

1) The caregiver or applicant to become a caregiver is required to pass a ~~Submit to central registry checks and national and~~ state criminal background check~~s~~ in compliance with Ark. Code Ann. §§ 20-~~33-213~~-77-128(c) ~~and 20-38-101 et seq. Criminal background checks shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.~~

2) If the caregiver or applicant to become a caregiver has not resided continuously in Arkansas during the previous five (5) years, they are required to submit to a federal criminal background check, including fingerprints.

F. ~~Obtains a Health Services card from the Division of Health. if requested~~Must successfully pass registry checks.

1) The caregiver or applicant to become a caregiver is required to pass registry records checks, including without limitation: registry records checks with the Child Maltreatment Central Registry and the Adult and Long-Term Care Facility Resident Maltreatment Central Registry;

2) A caregiver or applicant to become a caregiver who is on either the Child Maltreatment Central Registry or the Adult and Long-Term Care Facility Resident Maltreatment Central Registry shall not be employed to provide services paid with Medicaid funds.

G. May not be an individual who is considered legally responsible for the client, e.g., spouse or guardian

H. Must be 18 years of age or older; and

I. Must be able to perform the essential job functions required.

State of Arkansas
93rd General Assembly
Regular Session, 2021

A Bill

HOUSE BILL 1427

By: Representative Miller

For An Act To Be Entitled

AN ACT TO REQUIRE IN-HOME CAREGIVERS FOR MEDICAID BENEFICIARIES TO PASS REGISTRY RECORDS CHECKS IN ORDER TO BE PAID WITH MEDICAID FUNDS; TO CLARIFY REQUIREMENTS FOR REGISTRY RECORDS CHECKS AND CRIMINAL BACKGROUND CHECKS FOR IN-HOME CAREGIVERS OF MEDICAID BENEFICIARIES; AND FOR OTHER PURPOSES.

Subtitle

TO CLARIFY REQUIREMENTS FOR REGISTRY RECORDS CHECKS AND CRIMINAL BACKGROUND CHECKS FOR IN-HOME CAREGIVERS OF MEDICAID BENEFICIARIES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 20-77-128(a), concerning the definitions for in-home caregiver drug tests and criminal background checks, is amended to read as follows:

(a) As used in this section~~,~~:

(1) "Caregiver" ~~"caregiver"~~ means an individual who has responsibility for the protection, in-home care, or custody of a Medicaid enrollee as a result of assuming the responsibility by contract; and

(2) "Registry records check" means the review of one (1) or more database systems maintained by a state agency that contain information relative to the suitability of a person to be a caregiver.

SECTION 2. Arkansas Code § 20-77-128(c), concerning in-home caregiver

drug tests and criminal background checks, is amended to read as follows:

(c)(1) The ~~Department of Human Services~~ department shall:

(A) Require a state criminal background check of a caregiver and of an applicant to become a caregiver by the Identification Bureau of the ~~Department~~ Division of Arkansas State Police that conforms to the applicable standards; ~~and~~

(B) For a person who has not resided continuously in Arkansas during the previous five (5) years, require a federal criminal background check of a caregiver and of an applicant to become a caregiver by the Federal Bureau of Investigation that conforms to the applicable standards and includes the taking of fingerprints; and

(C) Require a registry records check of a caregiver and of an applicant to become a caregiver, including without limitation registry records checks with the Child Maltreatment Central Registry and the Adult and Long-Term Care Facility Resident Maltreatment Central Registry.

(2) A caregiver or an applicant to become a caregiver shall pay for the payment of any fee associated with the registry records check and the criminal background check required under this subsection.

(3)(A) Before a criminal background check is performed, a caregiver or an applicant to become a caregiver shall sign a release authorizing the criminal background check.

(B) Before a registry records check is performed, a caregiver or applicant to become a caregiver shall sign a release authorizing the registry records check.

(4) Upon completion of the criminal background check, the Identification Bureau of the ~~Department~~ Division of Arkansas State Police shall forward to the ~~Department of Human Services~~ department information obtained concerning the caregiver or applicant to become a caregiver ~~that indicates that~~ including whether the caregiver or applicant to become a caregiver has pleaded guilty or nolo contendere to or has been found guilty of a felony or crime involving moral turpitude or dishonesty.

(5) The results of the registry records check and the criminal background check shall be used by the ~~Department of Human Services~~ department to determine the suitability of:

(A) An applicant to become a caregiver paid with Medicaid funds; or

(B) A caregiver for continued employment paid with Medicaid funds.

(6)(A) A caregiver or applicant to become a caregiver who has pleaded guilty or nolo contendere to or has been found guilty of a felony or crime involving moral turpitude or dishonesty shall not be employed to provide services paid with Medicaid funds.

(B) A caregiver or applicant to become a caregiver who is on either the Child Maltreatment Central Registry or the Adult and Long-Term Care Facility Resident Maltreatment Central Registry shall not be employed to provide services paid with Medicaid funds.

(7) The registry records check and the criminal background information of a caregiver or applicant to become a caregiver is confidential.

APPROVED: 4/14/21