## Notice of Development of Rulemaking

## AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

RULE NO.: RULE TITLE:

59G-1.010 Definitions

PURPOSE AND EFFECT: The purpose of the amendment to Rule 59G-1.010, F.A.C., is to update definitions and adopt a definition of "usual and customary charge." The definition comports with the plain meaning of the term and is consistent with the requirement of cost effective purchasing of health services in the Florida Medicaid Program for all providers, except for pharmacy providers (as a definition already exists in the Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook, July 2014). The rule will require Medicaid enrolled providers, except for pharmacy providers, when listing their "usual and customary charge" to provide the price or fee that is most often or frequently accepted as payment by the provider for the particular service. The rule also explains the time period to be applied in calculating the usual and customary charge.

SUBJECT AREA TO BE ADDRESSED: An additional area to be addressed during the workshop will be the potential regulatory impact the amendment to Rule 59G-1.010 will have as provided for under Sections 120.54 and 120.541, F.S.

RULEMAKING AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.901-.9201 FS.

A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:

DATE AND TIME: Tuesday, September 9, 2014, 1:00 p.m. – 2:00 p.m.

PLACE: Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Conference Room D, Tallahassee, Florida 32308-5407

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 48 hours before the workshop/meeting by contacting: Mary McCullough. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Mary McCullough, Bureau of Medicaid Services, 2727 Mahan Drive, Mail Stop 20, Tallahassee, Florida 32308-5407, telephone: (850)412-4234, e-mail: mary.mccullough@ahca.myflorida.com

Comments will be received until 5:00 p.m. on Tuesday, September 16, 2014.

## THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

## 59G-1.010 Definitions.

The following definitions are applicable to all sections of Chapter 59G, <u>Florida Administrative Code (F.A.C.)</u>, unless specifically stated otherwise in one of those sections. These definitions do not apply to any Agency for Health Care Administration (Agency), Medicaid program rules other than those in Chapter 59G, F.A.C.:

- (1) "Abuse" is as defined in Section 409.913(1)(a), Florida Statute (F.S.)
- (2) "Active treatment plan" means a written plan of care or service implementation plan specific to an individual and which sets forth measurable goals or objectives stated in terms of desirable behavior and prescribing an integrated program of activities, experiences, or therapeutic interventions necessary for an individual to reach those goals or objectives. As applied to the community behavioral health service program, developmentally disabled recipients in the nursing home program, and intermediate care facility for individuals with intellectual disabilities (ICF/IID) services the developmentally disabled program, an active treatment plan focuses on treatment and services to address mental illness or developmental disabilities.
- (3) "Adjudicate" means to determine whether all program requirements have been met and whether the claim is payable.
  - (4) "Adjusted claim" means a claim to correct a previous payment.

- (5) "Adjustment" means the process or the result of the process by which a previous payment is corrected.
- (6) "Administrative hearing" means a formal or informal proceeding held in accordance with the provisions of Chapter 120, F.S. Florida Statutes.
- (7) "Administrative or grace days" are the days a patient remains in the hospital beyond the point of medical necessity while awaiting placement in a nursing home or other place of residence.
- (8) "Administrative sanctions" means the disincentives set forth in <u>sSections</u> 409.913(13), (14), (15), and (16), F.S., and Rule 59G-9.070, F.A.C.
- (9) "Admission review" means the evaluation of an individual's need for institutional care, goods, or services in accordance with established medical care and related criteria, including a determination of whether community based care is a viable alternative to institutionalization.
- (10) "Adult health screening" means a medical examination furnished to assess the health status of recipients age 21 years and older in order to detect and prevent disease, disability, and other adverse health conditions or their progression.
- (11) "Advanced <u>r</u>Registered <u>n</u>Nurse <u>p</u>Practitioner (ARNP)" means a registered nurse certified by the Florida Board of Nursing as an ARNP and who holds a valid and active license in full force and effect pursuant to <u>s</u>Section 464.012, F.S., or the applicable licensing laws of the state in which the service is furnished.
- (12) "Advanced registered nurse practitioner services" means services furnished within the context of advanced or specialized nursing practice.
- (13) "Adverse continued stay decision" means a decision, based on an assessment of an individual's medical and related needs, that terminates institutional care or services, or terminates payment to a provider.
  - (14) "Agency" means the Agency for Health Care Administration.
  - (15)(14) "Allied eeare" means care that is related to the health care needs of Medicaid recipients.
- (16)(15) "Allowable costs" means an item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with the Principles of Reimbursement for Provider Costs, as defined in HCFA Pub. 15 1 (formerly HIM 15), and as further defined in the Florida Title XIX Reimbursement Plans. Also see HCFA Pub. 15 1.
  - (17)(16) "Alternative placement" means placement in any setting other than an institution.
- (18)(17) "Ambulatory <u>s</u>Surgical <u>c</u>Center (ASC)" means a facility that is operated for the primary purpose of providing surgery not requiring inpatient hospitalization. The ASC is a facility that is licensed in accordance with the provisions of Chapter 395, F.S.
- (19)(18) "Appeal" means a request for a "Fair Hearing," an "Administrative Hearing," or review of the <u>Aagency</u>'s action by a court of competent jurisdiction.
- (20)(19) "Applicant," as applied to a prospective recipient, means an individual whose written application for medical assistance furnished by Medicaid under <u>s</u>ections 409.903 -.906, F.S., has been submitted to the <u>Aagency</u>, but has not received final action. This term includes an individual who is not alive at the time of application, but whose application is submitted through a representative or a person acting for the individual.
- (21)(20) "Attending physician" means a doctor of medicine or osteopathy licensed pursuant to Chapter 458 or 459, F.S., and who is identified as having primary responsibility for a recipient's medical care.
- (22)(21) "Audiologist" means an individual who holds a valid and active license in full force and effect pursuant to Chapter 468, Part I, F.S., or the applicable laws of the state in which the service is furnished.
  - (23)(22) "Audit" means either:
- (a) An examination of "records for audit" supporting amounts reported in the annual cost report or in order to determine the correctness and propriety of the report.; or
- (b) An analysis of documentation prepared in accordance with Medicaid policy and procedures supporting a provider's claim activity for a recipient's goods or services during a period of time in order to determine whether Medicaid payments are or were due and the amounts thereof.
  - (24)(23) "Baker Act" means the Florida Mental Health Act, Chapter 394, F.S.
- (25)(24) "Benefit" means any assistance, aid, obligation, promise, debt, liability, or the like, related to any covered injury, illness, or necessary medical or allied care, good, or services.
- (26)(25) "Billing agent" means a person or entity that has an agreement with a provider to submit Medicaid claims on behalf of the provider.

(27)(26) "Billing practitioner" means an entity that submits a claim on behalf of a Medicaid provider who has provided medical or allied care, goods, or services.

(28)(27) "Birth center" means any facility or institution licensed in accordance with the provisions of Chapter 383, F.S., and Chapter 10D-90, F.A.C., or the applicable laws of the state in which the service is furnished.

(29)(28) "Board certified" means certified by a medical specialty board approved by the American Board of Medical Specialties or American Osteopathic Association, or certified by a dental specialty board of the American Dental Association.

(30)<del>(29)</del> "Bribe, Kickback, or Illegal Solicitation" means:

- (a) Knowingly and willfully soliciting or receiving any remuneration directly or indirectly, overtly or covertly, in cash or in kind, from any person in return for either:
- 1. Referring or taking an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the Medicaid or other health care program unless such arrangement has been made with or approved by the Agency. Or
- 2. Purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under the Medicaid program or other health care program unless such arrangement has been made with or approved by the Agency.
- (b) Knowingly or willfully offering or paying any remuneration directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce such person to either:
- 1. Refer or take an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the Medicaid program or other health care program, unless such arrangement has been made with or approved by the Agency\_<del>\_, or</del>
- 2. Purchase, lease, order, arrange for any recommended purchase, lease, or order of any good, facility, service or item for which payment may be made in whole or in part under the Medicaid program or other health care program, unless such arrangement has been made with or approved by the Agency.
- (31)(30) "Business records" are those documents related to the administrative or commercial activities of a provider, as contrasted with medical or professional activities. Business records made available to Medicaid must be dated and legible. Business records include, as applicable, admission, accident, appointment, assignment, billing, contract, eligibility, financial, insurance, legal, medical release, patient activity, peer review, personnel, procurement, registration, signature authorization, tax, third party correspondence, utilization review documents, all administrative or commercial records that are customarily prepared or acquired and are customarily retained by the provider, and administrative or commercial records that are required by statute or rule to be prepared or acquired and retained by the provider. Records may be on paper, magnetic material, film or other media. Also see "Medical records" and "Medicaid\_related records."

(32)(31) "Cap" sSee "Service limit."

(33)<del>(32)</del> "Cap period" sSee "Service limitation period."

(34)(33) "Capitation payment" means the monthly fee that is paid by the Agency department to a contractor or provider for each Medicaid recipient enrolled under a contract for the provision of Medicaid services, whether or not the enrollee receives the services during the payment period.

(35)(34) "Care plan" sSee "Plan of care."

(36)(35) "Case management" means the manner or practice of planning, directing, and coordinating the health care and utilization of medical and allied services of recipients.

(37)(36) "Case manager" means an employee of the <u>Agency</u> department or a case management contractor approved by the <u>Agency</u> department who furnishes case management services directly to or on behalf of a recipient on an individual basis.

(38)(37) "Certification" means the process of determining that a facility, equipment, or an individual meets the requirements of federal or state law, or whether Medicaid payments are appropriate or will be made in certain situations.

(39)(38) "Certification statement" means a statement by which a physician or other authorized professional personnel attest to an individual's need for a specific type or level of coverage under the Medicaid program.

- (40)(39) "Chiropractor" means a doctor of chiropractic medicine who holds a valid and active license in full force and effect pursuant to the provisions of <u>sSection 409.906</u> 460.403, F.S., or the applicable laws of the state in which the service is furnished.
- (41)(40) "Claim" means any communication, whether oral, written, electronic, or otherwise, that is used by any person to apply for payment from the Medicaid program or its fiscal agent for each item or service purported by any person to have been furnished by a person to any Medicaid recipient or other individual.
- (42)(41) "Claims detail" means a report of information generated by a computer or any other means concerning claims submitted to the Medicaid program. Also see "Payment rRecord."
- (43)(42) "Clean claim" means a claim that has been completed properly according to Medicaid billing guidelines, is accompanied by all necessary documentation required by federal law, state law, or state administrative rule for payment, and can be processed and adjudicated without obtaining additional information from the provider or from a third party. It includes a claim with errors originating in the Agency's department's claim system. It does not include a claim from a provider who is under investigation for fraud, abuse, or violation of state or federal Medicaid laws, rules, regulations, policies, or directives, or a claim under review for medical necessity.
- (44)(43) "Client assessment or reassessment" means formal tools or informal techniques used by a health care provider or case manager to identify the medical, social, educational or other needs of a recipient.
- (45)(44) "Clinic" means a facility that is organized and operated independent of any institution to furnish preventive, diagnostic, therapeutic, rehabilitative, or palliative Medicaid care, goods, or services to outpatients.
- (46) "Centers for Medicare & Medicaid Services (CMS)," previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.
- (47)(45) "Coinsurance Co insurance" means an amount that a Medicare beneficiary pays to a provider for furnishing medical or allied care, goods, or services.
- (48)(46) "Collateral" means any and all causes of action, suits, claims, counterclaims, and demands that accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical or allied care, goods, or services for which Medicaid provided medical assistance; all judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments; and proceeds as defined in <u>s</u>Section 409.901, F.S.
  - (49)(47) "Compensable services" sSee "Medicaid services."
- (50)(48) "Comprehensive Assessment and Review (CARES)" means an institutional care preadmission assessment and screening program administered or arranged by the Department of Elder Affairs.
- (51)(49) "Concurrent care" means care furnished at the same time to a Medicaid recipient by physicians of more than one specialty when the patient's condition requires such care.
- (52)(50) "Consultation" means an opinion rendered by a health professional at the request of another health professional in accordance with Medicaid rules, regulations, policies, and directives.
  - (53)(51) "Contracting officer" means the Deputy Assistant Secretary of Medicaid.
- (54)(52) "Contractor" means any entity under contract with the <u>Aagency</u>. The term contractor shall include all employees, subcontractors, agents, volunteers, and anyone acting on behalf of, in the interest of, or for a contractor.
- (55)(53) "Copayment Co payment" means an amount that a recipient is required by Medicaid policy to pay a provider for furnishing medical or allied care, goods, or services.
- (56)(54) "Corrective action plan" means a written plan of action developed by the facility for the purpose of correcting cited deficiencies in compliance with federal or state regulations, rules, or policies.
  - (57)(55) "Cosmetic" means furnished for aesthetic purposes.
- (58)(56) "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which Medicaid is, or may be, obligated to provide, or has provided, medical assistance.
- (59)(57) "Covered services" are those medical or allied care, goods, or services determined by the Agency department to be eligible for reimbursement pursuant to Medicaid program standards, and those Medicaid and other medical or allied care, goods, or services that a prepaid health plan contractor agrees to furnish under the terms of its contract with the Agency department. Also see "Medicaid services."

- (60)(58) "Covered procedures" sSee "Medicaid services."
- (61)(59) "CPT-4 procedure codes" means the <u>most current addition of</u> Physicians Current Procedural Terminology, Fourth Edition, CPT, which is a systematic listing and coding of procedures and services that is published yearly by the American Medical Association.
- (62)(60) "Crossover" or "Crossover claim" means a claim that is submitted to Medicare and subsequently submitted to Medicaid for payment of the deductible or coinsurance.
- (63)(61) "Date of service (DOS)" means the date on which the provider furnished medical or allied care, goods, or services to a Medicaid eligible recipient, unless specified otherwise for a particular service.
- (64)(62) "Dentist" means an individual who holds a valid and active license to practice dentistry or dental surgery in full force and effect pursuant to the provisions of Chapter 466, F.S., or the applicable laws of the state in which the service is furnished.
  - (63) "Agency" means the Agency for Health Care Administration.
- (64) "DESI" means Drug Efficacy Study Implementation, and is used to identify drug products and known related drug products that have been identified by the Health Care Financing Administration as lacking substantial evidence of effectiveness.
- (65) "Diagnosis and evaluation (D & E)" means the process of preparing a comprehensive assessment of a person's performance level in several health, social, mental, and personal abilities by an interdisciplinary team of professionals. D & E includes a detailed listing of the individual's service needs and a care plan or service plan that includes the services the individual requires to attain measurable objectives.
- (66) "Diagnosis and evaluation (D & E) team" means an interdisciplinary team of professionals that evaluates an individual in order to determine his eligibility for developmental services, determine his service needs, and develop a plan of care for the provision of needed medical or allied care, goods, or services.
- (67) "Directive" means any statement of general instruction as to procedure communicated to a provider through means such as handbooks, manuals, guidelines, bulletins, letters, and other types of communication as the <u>Agency department</u>, in its discretion, may determine to be appropriate to sufficiently apprise a provider of its compliance requirements.
- (68) "Disenrollment" means the discontinuance of an enrollee's membership in a contractor's prepaid plan, of an enrollee's participation in a provider's enrolled caseload, or of an enrollee's participation in a federally-approved waiver program. Also see "Enrollee."
  - (69) "District" means a geographic service area of the department as defined in Section 20.19, F.S.
- (70) "Drug Efficacy Study Implementation (DESI)" is used to identify drug products and known related drug products that have been identified by CMS as lacking substantial evidence of effectiveness. "Drug exception request (DER)" means the process through which a change to a recipient's monthly drug service limit may be allowed.
- (71) "Dually eligible recipient" means any person who is eligible to receive benefits under both the Florida Medicaid program, Title XIX, and the federal Medicare program, Title XVIII.
- (72) "Durable medical equipment (DME)" means medical equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose; is generally not useful in the absence of illness or injury; and is appropriate for use in the patient's home. Also see "Goods," "Medical supplies," and "Supplies and appliances."
  - (73) "Election" means the selection of hospice services by the individual or the individual's representative.
  - (74) "Elective surgery" means surgery that can be safely deferred without:
  - (a) Threatening the life of the patient,
  - (b) Causing irreparable physical damage,
  - (c) Resulting in the loss or serious impairment of a body function, or
  - (d) Rresulting in irretrievable loss of growth and development-
  - (75) "Eligible person" sSee "Recipient."
- (76) "Emergency care" or "emergency services" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the emergency medical

condition, within the service capability of a hospital or "emergency medical services" means those services that are necessary to prevent loss of life, irreparable physical damage, or loss or serious impairment of a body function.

- (77) "Enrollee" means an eligible recipient who is a member of a contractor's prepaid plan, or who is enrolled in a primary care case manager's caseload or a federally approved waiver program.
- (78) "EPSDT" means the Early and Periodic Screening, Diagnosis and Treatment program administered by the Medicaid program.
- (79) "Erroneous Payment" means a payment made to a Medicaid recipient, provider, or other person to which he is not entitled and which is caused by intentional or inadvertent error by the recipient, provider, or other person.
- (80) "Established patient" means a patient who has received professional medical or allied care, goods, or services from the provider within the past three years.
- (81) "Estimated Acquisition Cost" or "(E.A.C.)", as related to the Medicaid prescribed drug program, means the cost established by the department's best estimate of the price generally and currently paid by providers.
- (82) "Exception" or "Exception authorization" means a determination by the <u>Agency department</u> allowing for the provision of and payment for medical or allied care, goods, or services that otherwise would not be reimbursable due to service limitations.
- (83) "Expanded benefit" means a covered service of a prepaid health plan that either is not a Medicaid covered service, or is a Medicaid covered service furnished by a prepaid plan for which the plan receives no capitation payment.
- (84) "Experimental" or "Experimental and clinically unproven" or "Investigational" as related to drugs, devices, medical treatments or procedures means <u>either</u>:
- (a)1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished.; or
- 2. Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.; or
- 3. Reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis.
  - 4. The drug or device is used for a purpose that is not approved by the FDA.
- (b) Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.
- (85) "Fair Hearing" means the opportunity afforded any Medicaid applicant or recipient, for whom there has been a determination to deny, reduce or terminate benefits or services, except when the determination is due solely to a law or policy requiring an automatic change, to have one or more impartial officials who have not been directly or indirectly involved in the initial determination of the action in question render a final decision based on information submitted for review pursuant to the hearing standards contained in federal regulations.
- (86) "Family planning" means services rendered for the purpose of enabling persons to voluntarily plan family size or plan the length of time between births.
- (87) "Family Service Plan or Family Support Plan (FSP)" means a department accepted plan of care for the entire family including health care, economic assistance, equipment, and education.
  - (88) "FDHRS" stands for Florida Department of Health and Rehabilitative Services.
- (89)(88) "Fee-for-service" means a method of making payment for medical or allied care, goods, or services based on fees set by the Agency department for defined care, goods, or services.

(90)(89) "Felony," means any act that:

- (a) Is a felony under Florida law or would be punishable as a felony had the act been committed in Florida.
- (b) Is a felony under federal law or would be punishable as a felony had the act been committed under federal jurisdiction.

- (90) "Fiscal agent" means any corporation or other legal entity that has contracted with the <u>Agency</u> department to receive, process, and adjudicate claims under the Medicaid program.
- (91) "Florida Medicaid Management Information System (FMMIS)" means the computer system used to process Florida Medicaid claims and to produce management information relating to the Florida Medicaid program.
- (92) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- (93) "Freedom of Choice" means the right of a Medicaid recipient to choose from all programs for which he is eligible and to choose any enrolled Medicaid provider from whom to obtain medical or allied care, goods, or services.
- (94) "Furnished" means supplied, given, prescribed, ordered, provided, or directed to be provided in any manner.
- (95) "Generic upper limit price (GULP)" means the upper payment limit established by the department for generic equivalent drug products.
- (96) "Goods" means appliances, equipment, supplies, or other items of merchandise normally or usually recognized by medical professionals as medically necessary in the treatment of the covered illness or injury, or in the rehabilitation from same, including drugs and durable medical equipment. Also see "Durable medical equipment," "Medical supplies," "Prescribed drugs," "Prosthetic device," and "Supplies and appliances."
  - (97) "Grace days" See "Administrative or grace days."
- (98) "Grievance" means a formal complaint filed with the <u>Agency</u> department by a managed care enrollee or the enrollee's agent that expresses dissatisfaction with care, goods, services, or benefits received under the program in which the person is enrolled.
- (99) "Grievance procedure" means an organized process by which managed care enrollees may express dissatisfaction with care, goods, services, or benefits received under the program in which they are enrolled and the resolution of these dissatisfactions.
- (100) "Group" or "Group practice" means two or more health care practitioners who practice their profession at a common location, whether or not they share common facilities, supporting staff, or equipment, and which organization possesses a federal employer identification (FEI) number.
- (101) "Habilitation plan or Individual Support Plan" means a plan for providing programs and services to an individual based on a joint interdisciplinary professional diagnosis and evaluation process, consisting of at least a complete medical, social, and psychological assessment. The habilitation plan identifies barriers to optimum independent functioning and targets behaviors to be achieved by the individual over a specified period and also provides the basis for the development of the active treatment plan in an ICF/IIDMR-DD facility.
- (102) "HCFA Pub. 15 1 (formerly HIM 15)" means publication 15 1, also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Health Care Financing Administration (HCFA). This manual details cost finding principles for institutional providers for Medicare and Medicaid reimbursement.
- (102)(103) "Healthcare Common Procedure Coding System (HCPCS)" means the national method of classifying written descriptions of diseases, injuries, conditions, procedures, and supplies using alphabetic and numeric designations or codes.
- (104) "Health Care Financing Administration (HCFA)" means the unit of the United States Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII and Medicaid under Title XIX of the Social Security Act.
- (103)(105) "Health coverage" means health insurance, disability insurance, multiple employer welfare arrangements, health maintenance organizations, or prepaid health clinics as defined in section ss. 624.603, 624.437, and 641.19(5), and 641.402(6), F.S.
- (104) "Health Insurance Claim Form 1500," formerly known as the CMS-1500, is the claim form used for payment from Medicaid through the fiscal agent.
- (105)(106) "Health Maintenance Organization (HMO)" means an entity certified by the Florida Department of Insurance under applicable provisions of Part I H of Chapter 641, F.S., or as defined in the Florida Medicaid State Plan.

(106)(107) "HHS" means the federal Department of Health and Human Services.

(107)(108) "Hearing aid specialist" means an individual who holds a valid and active license to practice the dispensing of hearing aids in full force and effect pursuant to the provisions of Chapter 484, Part II, F.S., or the applicable laws of the state in which the service is furnished.

(108)(109) "High medical risk pregnant woman" means a woman whose medical history and diagnosis indicate, without consideration of a previous caesarean section, that a normal uncomplicated pregnancy and delivery is unlikely to occur.

(109)<del>(110)</del> "HIM-15" See HCFA-Pub. 15-1.

(110)(111) "Home Health Aide Aid (HHA)" means a person who has successfully completed a training program that meets minimum standards for aide training as determined by the Office of Licensure and Certification and the Florida Department of Education, and who furnishes personal health care services for a recipient at home under the supervision of a licensed health care worker.

(111)(112) "Hospice" means a licensed public agency or private organization, or autonomous unit within either, that is primarily engaged in providing a continuum of services to terminally ill individuals and that meets the Medicare participation standards specified in 42 CFR Part 418.

(112)(113) "Hospital" means a facility licensed in accordance with the provisions of Chapter 395, F.S., or the applicable laws of the state in which the service is furnished.

(114) "HRS" means the Florida Department of Health and Rehabilitative Services.

(113)(115) "ICD-9-CM dDiagnosis and pProcedure cCodes" means the most current addition of International Classification of Diseases, 9th Revision, Clinical Modification, which is a method of classifying written descriptions of diseases, injuries, conditions, and procedures using alphabetic and numeric designations or codes.

(114)(116) "Illegal Solicitation" see "Bribe, Kickback, or Illegal Solicitation."

(115)(117) "Inappropriate payment" means all or a portion of a payment made to any person or provider to which the provider is not entitled as determined by the Medicaid program.

(116)(118) "Independent" means not under common control or governance, direct or indirect ownership.

(117)(119) "Independent laboratory" means a facility other than a hospital or clinic that is certified in accordance with the Clinical Laboratory Improvement Act (CLIA) of 1988 standards to provide diagnostic laboratory services.

(118)(120) "Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in another entity.

(119)(121) "Individual Support plan" See "Habilitation plan."

(120)(122) "Infirmary" means that area of a facility where the infirm or sick are lodged for temporary care or treatment.

(121)(123) "Inpatient" means a person who has been admitted to a hospital for purposes of receiving inpatient hospital services with the expectation that he will remain at least overnight and occupy a bed even though through it may later develop that he can be discharged or transferred to another hospital and does not actually use the hospital bed overnight. Also see "Outpatient."

(122)(124) "Insolvency" means a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

(123)(125) "Inspection of Care" means a periodic on-site review and evaluation of care and services furnished to Medicaid residents by institutional care facilities.

(124)(126) "Institutional care facility" means a nursing home, an (ICF/IID) intermediate care facility for mentally retarded/developmentally disabled (ICF/MR DD), or a state mental hospital licensed in accordance with the provisions of Chapter 395 or 400, F.S.

(125)(127) "Institutional services" means care furnished in an institutional care facility.

(126)<del>(128)</del> "Institutionalized person" means a person who is:

- (a) Involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness; or
- (b) Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness; or
  - (c) A resident of or admitted to an institution.

(127)(129) "Insurer" means an entity authorized to furnish health care or health care insurance coverage.

(128)(130) "Interdisciplinary team" means a group of persons consisting of representatives of all professional disciplines involved in the care of the institutional care facility resident and participating in the development and implementation of an individual medical, nursing, rehabilitative and active treatment plan to achieve a unified and integrated program for meeting the individual's needs.

(129)(131) "Intermediate care facility for the <u>individuals with intellectual disabilities (ICF/IID) mentally</u> retarded/developmentally disabled (ICF/MR DD)" means a facility licensed under state law and certified under federal regulations to furnish health care, rehabilitative services, and other related services to individuals who have an intellectual disability mental retardation, a developmental disability or related conditions.

(130)(132) "Intermediate care resident" means a Medicaid applicant or recipient and nursing home resident who requires intermediate care services including 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and treatment furnished in a hospital or that which meets the criteria for skilled nursing services as defined in Rule 59G-4.290, F.A.C.

(131)(133) "Intermittent" or "Intermittent Nursing Care" as related to furnishing medical or allied care, goods, or services to recipients means that there is a medically predictable need for the care, goods, or services to be provided from time to time, but usually not less frequently than once every sixty days, and that they are needed on an acute episodic basis but not a maintenance basis. The fact that a provider has used the term "intermittent" in furnishing, prescribing, recommending, or approving care, goods, or services does not, in itself, make such care, goods, or services intermittent for Medicaid purposes.

(132)(134) "Investigation" means the activities to determine whether there exist issues of non-compliance with the laws, rules or policies governing the Medicaid Program, and other laws under which the Agency has authority.

(133)(135) "Kickback" see "Bribe, Kickback, or Illegal Solicitation."

(134)(136) "Knowingly" means that a person is aware or should be aware of the nature of his conduct and that his conduct is substantially certain to cause the result at issue.

(135)(137) "Legal representative" means a guardian, conservator, survivor, or personal representative of a recipient or applicant, or of the property or estate of a recipient or applicant.

(136)(138) "Legend drugs" means those drugs for which federal law requires the federal legend label, "Caution: Federal Law prohibits dispensing without a prescription", or those drugs that state law prohibits dispensing without a prescription.

(137)(139) "Level of care" means the level of nursing or rehabilitative care required by a Medicaid applicant or recipient based on his medical or related needs as defined by the criteria in Chapter 59G-4, F.A.C.

(138)(140) "Licensed practical nurse (LPN)" means a graduate of an approved formal program of study in practical nursing who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 464, F.S., or the applicable laws of the state in which the service is furnished.

(139)(141) "Licensed" means a facility, a piece of equipment, a system, or an individual has formally met and is registered in accordance with all state, county, and local requirements applicable to the particular license, and has authorization from the applicable competent authority to do an act which, without such authorization, would be illegal.

(140)(142) "Lock-in" means the restriction of a Medicaid recipient to a single provider or health plan that is enrolled or under contract with the Agency and that agrees to be responsible for the provision or authorization of services for that recipient.

(141)(143) "Low medical risk pregnant woman" means a woman whose medical history and diagnosis indicate, without consideration of a previous caesarean section, that a normal uncomplicated pregnancy and delivery are likely to occur.

(142)(144) "Maintenance drugs" are those drugs prescribed for the treatment of a known chronic disorder and all drugs prescribed for longer than two (2) consecutive months for the treatment of a disease state.

(143)<del>(145)</del> "Management" See "Case management" and "Patient management."

(144)(146) "Managing employee" means a general manager, business manager, administrator, director, or other person who exercises operational or managerial control of a provider, or who directly or indirectly conducts the day-to-day operations of a provider.

(145)(147) "Mandatory coverage groups" means those groups of individuals required to be covered by Medicaid in accordance with the provisions of federal law and Chapter 409, F.S. Also see "Optional coverage groups."

(148) "Marketing" as it pertains to prepaid health plans means activity conducted by or on behalf of the contractor and that is intended to encourage Medicaid recipients to enroll in the contractor's prepaid health plan.

(146)(149) "Medicaid" means the medical assistance program authorized by Title XIX of the federal Social Security Act, 42 U.S.C., section- 1396 et seq., and regulations there under thereunder, as administered in this state by the Agency department under section 409.901 et seq., F.S.

(147)(150) "Medicaid agency" means the single state agency that administers or supervises the administration of the Medicaid state plan under federal law.

(148)(151) "Medicaid Fraud Control Unit (MFCU)" means the unit so designated in the Office of the Attorney Auditor General of the state of Florida.

(149)(152) "Medicaid Identification Card" means a card furnished to Medicaid recipients that is used by providers to verify eligibility.

(153) "Medicaid Physician Access System (MediPass)" means the physician primary care case management waiver program operated by the department.

(150)(154) "Medicaid-related records" means records that relate to the provider's business or profession and to a Medicaid recipient. Medicaid-related records include records related to non-Medicaid customers, clients, or patients, to the extent that the documentation is shown by the <u>Agency department</u> to be necessary to determine a provider's entitlement to payments under the Medicaid program. Also see "Business records" and "Medical records."

(151)(155) "Medicaid services" or "Medicaid care" means medically necessary medical or allied institutional or noninstitutional care, goods, services, or procedures covered, and eligible for payment, by the Medicaid program. Also see "Medically necessary."

(152)(156) "Medical assistance" means any provision of, payment for, or liability for medical or allied care, goods, or services by Medicaid to, or on behalf of, any recipient.

(153)<del>(157)</del> "Medical care" See "Medical services."

(154)(158) "Medical care evaluation study" means a study performed by a facility's Utilization Review Committee (URC) that identifies and analyzes patterns of care furnished to Medicaid inpatient hospital residents.

(155)(159) "Medical foster home" means a residential facility where medical foster care is furnished to medically complex children in a family living environment, which also includes supervision and care necessary to meet the physical, emotional, and social needs of the children.

(156)(160) "Medical records" means those documents corresponding to medical or allied care, goods, or services furnished in any place of service. The records may be on paper, magnetic material, film, or other media. In order to qualify as a basis for reimbursement, the medical records must be dated, signed or otherwise attested to, as appropriate to the media, and legible.

- (a) Medical records will include, as applicable:
- 1. Date of service on each visit, and time spent with patient on each visit;
- 2. Place of service;
- 3. Patient's name and date of birth;
- 4. Caregiver's signature (not stamp or facsimile), and name and title of person performing the service. When the caregiver is the billing practitioner, the name and title must appear on the claim form;
  - 5. Referring physician;
  - 6. Chief complaint on or purpose of each visit;
  - 7. Medical history;
  - 8. Findings on examination;
  - 9. Medications administered, prescribed or dispensed;
  - 10. Description of treatment, when applicable;
- 11. Daily progress notes, physician's orders, prescriptions, and recommendations for additional treatments or consultations;
  - 12. Laboratory reports, X-ray and other image records, and other tests and results;
  - 13. Documentation related to medical equipment and supplies ordered or prescribed; and

- 14. All other records that are customarily prepared or acquired, and are customarily retained by the provider and all records that are required by statute or rule to be prepared or acquired and retained by the provider.
  - (b) Also see "Business records" and "Medicaid-related records."
- (157)(161) "Medical review" means a process by which certain claims submitted to the Medicaid fiscal agent for payment are reviewed by Agency department medical consultants to determine their final adjudication.
- (158)(162) "Medical services" means medical or allied institutional or noninstitutional care, goods, services, or procedures. Also see "Medicaid services."
- (159)(163) "Medical supplies" means medical or surgical items that are consumable, expendable, disposable or non-durable and that are used for the treatment or diagnosis of a patient's specific illness, injury, or condition. Also see "Goods," "Durable medical equipment," and "Supplies and appliances."
- (160)(164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24 hour-per-day medical, nursing, or health supervision or intervention.
- (161)(165) "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.
- (162)(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
  - (a) Meet the following conditions:
  - 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
- 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
- (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
- (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
- (163)(167) "Medicare" means the medical assistance program authorized by Title XVIII of the federal Social Security Act, 42 U.S.C., s. section 1395 395 et seq., and regulations thereunder.
- (164) (168) "Mental health treatment" means mental health services that are furnished to persons, individually or in groups, including counseling, supportive therapy, ehemotherapy, intensive psychotherapy, and such other accepted therapeutic processes as qualify for Medicaid reimbursement.
- (165)(169) "Mentally incompetent person" means an individual who has been declared mentally incompetent by a court of competent jurisdiction for any purpose, unless the person has been declared competent for purposes that include the ability to consent to the specific medical procedure in question.
  - (166)(170) "Misdemeanor," means any act that:
- (a) Is a misdemeanor under Florida law or would be punishable as a misdemeanor had the act been committed in Florida.
- (b) Is a misdemeanor under federal law or would be punishable as a misdemeanor had the act been committed under federal jurisdiction.
- (167)(171) "Misutilization" means the utilization or the furnishing of and billing for Medicaid services that are inappropriate or unnecessary or are not furnished in accordance with generally accepted professional standards of health care. Also see "Fertilization" and "Underutilization."

(168)(172) "Monitor" means to perform an evaluation of a provider's practice.

(169)(173) "Neonatal-perinatologist" means a physician who is certified or meets the requirements for certification as a neonatal-perinatologist by the American Board of Ppediatrics, Sub-board of Neonatal-Perinatology Medicine.

(170)(174) "Neurologist" means a physician who is certified or meets the requirements for certification as a neurologist by the American <u>B</u>board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(171)(175) "New patient" means a patient who has not received any professional medical or allied care, goods, or services from the provider or the provider group within the past three years.

(172)(176) "Non-clinical in-home mental health care services" are medically necessary therapeutic services that address the special mental health needs of Medicaid eligible children and that are furnished as a component of a care plan.

(173)(177) "Non-contract provider" means any person, organization, agency, or entity that is not directly or indirectly employed by a contractor or any of its subcontractors. Also see "Contractor" and "Provider."

(174)(178) "Nurse practitioner" See "Advanced Registered Nurse Practitioner."

(175)(179) "Nursing facility" means an institutional care facility licensed under Chapter 395 or 400, F.S., that furnishes medical or allied inpatient care and services to individuals needing such services.

(176)(180) "Occupational therapist" means an individual who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 468, F.S., or the applicable laws of the state in which the service is furnished, and who is registered with the American Occupational Therapy Association.

(177)(181) "Occupational therapist assistant" means an individual who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 468, F.S., or the applicable laws of the state in which the service is furnished, and who is a graduate of a two year college level program approved by the American Occupational Therapy Association.

(178)(182) "Office of Health Facility Regulation" means the office designated by Florida Statutes as having responsibility for the federal certification and state licensure of a variety of health care facilities, laboratory professionals, and other service organizations.

(179)(183) "Ophthalmologist" means a physician who specializes in the treatment of disorders of the eye as defined in Chapter 458, F.S.

(180)(184) "Optician" means an individual who holds a valid and active license to practice opticianry in full force and effect pursuant to the provisions of Chapter 484, Part I, F.S., or the applicable laws of the state in which the service is furnished.

(181)(185) "Optional coverage groups" means those groups of individuals who may, at the option of the <u>Agency</u> department, be covered by Medicaid in accordance with the provisions of federal law and Chapter 409, F.S. Also see "Mandatory coverage groups."

(182)(186) "Optometrist" means an individual who holds a valid and active license to engage in the practice of optometry in full force and effect pursuant to the provisions of Chapter 463, F.S., or the applicable laws of the state in which the service is furnished. A "certified optometrist" means an optometrist who is authorized to administer and prescribe topical ocular pharmaceutical agents.

(183)(187) "Orthotic device" or "orthotic" means a device or appliance to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

(184)(188) "Otolaryngologist" means a physician who specializes in the conditions and diseases of the ears, nose, and throat.

(185)(189) "Otologist" means a physician who specializes in the conditions and diseases of the ears.

(186)(190) "Outpatient" means a patient of an organized medical facility or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight. Also see "Impatient."

(187)<del>(191)</del> "Overpayment" is as set forth in Section 409.913, F.S.

(188)(192) "Overutilization" means the utilization or the furnishing of and billing for Medicaid care, goods, or services that are in excess of those that reasonably would be expected to benefit the health of a recipient based on the recipient's disease or diagnosis and on generally accepted professional standards of health care.

(189)(193) "Ownership interest" means the possession of equity in the capital, the stock, or the profits of a business, prepaid health plan contractor or applicant, or other entity. Ownership interest may be direct or indirect. Also see "Indirect ownership interest."

(190)(194) "Part-time" as related to furnishing medical or allied care, goods, or services to recipients means that the care, goods, or services are needed on a less than continuous basis. Such care, goods, or services are needed on a fixed beginning date and a projected ending date determined at the time the services are ordered. The fact that a provider has used the term "part-time" in furnishing, prescribing, recommending, or approving care, goods, or services does not, in itself, make such care, goods, or services part-time for Medicaid purposes.

(191)(195) "Patient management" means the responsibility for managing the primary health care of a recipient and coordinating access to other necessary medical or allied services.

(192)(196) "Payment record" means a record of claims paid to a specific provider for Medicaid care, goods, or services. Also see "Claims detail."

(193)(197) "Peer" means a person who has equal professional status with a Medicaid provider of a specific type or specialty. Where a person with equal professional status is not reasonably available, a peer includes a person with substantially similar professional status.

(194)(198) "Peer review" means an evaluation of the professional practices of a Medicaid provider by a peer or peers of the provider in order to assess the necessity, appropriateness, and quality of care furnished as such care is compared to that customarily furnished by the provider's peers and to recognized health care standards. A peer reviewer may be employed or contracted by the Agency to provide medical or allied consulting services.

(195)(199) "Peer review committee" means a committee of a provider's peers that has contracted with the Agency to review and report on the professional practices of the provider at the Agency's direction.

(196)(200) "Person" means natural persons, corporations, partnerships, associations, clinics, groups, and includes all other similar entities.

(197)<del>(201)</del> "Person with an ownership or control interest" means a person or corporation that:

- (a) Has an ownership interest equal to 5 percent or more in a contractor or provider;
- (b) Has an indirect ownership interest equal to 5 percent or more in a contractor or provider;
- (c) Has a combination of direct and indirect ownership interest equal to 5 percent or more in a contractor or provider;
- (d) Has an ownership interest equal to 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the contractor or provider if that interest equals at least 5 percent of the value of the property or assets of a contractor or provider;
- (e) Is an officer or director of a contractor or provider that is organized as a corporation, or is an officer or director in an entity that has an indirect ownership interest in the contractor or provider; or
- (f) Is a partner in a contractor or provider that is organized as a partnership, or is a partner in an entity that has an indirect ownership interest in the contractor or provider.

(198)<del>(202)</del> "Personal care" means medically necessary assistance with daily living activities.

(199)(203) "Pharmacist" means a person who holds a valid and active license to practice the profession of pharmacy in full force and effect pursuant to the provisions of Chapter 465, F.S., or the applicable laws of the state in which the service is furnished.

(200)(204) "Pharmacy provider" means a pharmacy with a valid permit issued pursuant to the provisions of Chapter 465, F.S., or the applicable laws of the state in which the pharmacy is located, and that is enrolled as a provider of Medicaid pharmacy goods or services.

(201)(205) "Physical abuse" means harming a recipient by force or through neglect, whether intentional or inadvertent. Refer to Section 409.913(16)(d) s. 409.913(10)(d), F.S.

(202)(206) "Physical examination" means a personal, face-to-face contact with a Medicaid recipient by a licensed physician or by another licensed medical professional under the personal supervision of a physician, for the purpose of diagnosis and treatment of medical disorders.

(203)(207) "Physical therapist" means an individual who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 486, F.S., or the applicable laws of the state in which the service is furnished, and who is a graduate of an American Physical Therapy Association approved program.

(204)(208) "Physical therapist assistant" means an individual licensed pursuant to the provisions of Chapter 486, F.S., or the applicable laws of the state in which the service is furnished, and who is a graduate of a two-year college-level program approved by the American Physical Therapy Association.

(205)(209) "Physician" means a doctor of medicine or osteopathy who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 458 or 459, F.S., or the applicable laws of the state in which the service is furnished.

(206)(210) "Physician assistant" means an individual certified by the Board of Medical Examiners to practice as a physician assistant pursuant to the provisions of Chapter 458 or 459, F.S., or the applicable laws of the state in which the service is furnished.

(207)(211) "Physician check-up" means a routine physical examination in the absence of a specific problem.

(208)(212) "Physician consultant" means a doctor of medicine or osteopathy, licensed pursuant to the provisions of Chapters 458 or 459, F.S., who is employed by the <u>Agency department</u> to provide medical or allied consulting services.

(209)(213) "Place of service (POS)" means the physical location at which a provider renders Medicaid care, goods, or services to or for a recipient.

(210)(214) "Plan of care" or "Plan of treatment" means an individualized written program for a recipient that is developed by health care professionals based on the need for medical care established by the attending physician and designed to meet the health and/or rehabilitation needs of a patient.

(211)(215) "Podiatrist" means a doctor of podiatric medicine who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 461, F.S., or the applicable laws of the state in which the service is furnished.

(212)(216) "Podiatry" means the diagnosis and medical, surgical, palliative, and mechanical treatment of ailments of the human foot and leg, as defined in Chapter 461, F.S.

(213)(217) "Portable X-ray equipment" means X-ray equipment transported to a setting other than a hospital, clinic, or office of a physician or other practitioner of the healing arts.

(214)(218) "Portable X-ray provider" means a supplier of portable X-ray services that is certified by Medicare in accordance with Title XVIII standards.

(215)(219) "Post authorization" means approval to bill Medicaid for medical or allied care, goods, or services obtained by a provider from the <u>Agency</u> department, or from a provider under contract with the <u>Agency</u> department to manage a client's care, after the care, goods, or services have been furnished.

(216)(220) "Prepaid health plan" or "prepaid plan" means a contractual arrangement between the Agency department and a contractor for the provision of Medicaid care, goods, or services on a prepaid basis.

(217)(221) "Prescribed drugs" means simple or compound substances or mixtures of substances that are prescribed for the cure, mitigation, or prevention of disease or for health maintenance and that are prescribed by a licensed practitioner authorized by the laws of the state to prescribe such substances, dispensed by a licensed pharmacist or licensed dispensing practitioner in accordance with the laws of the state in which the practitioner is licensed, and dispensed on a prescription that is recorded in and retrievable from the pharmacist's or practitioner's records

(218)(222) "Prescribed Pediatric Extended Care (PPEC) Center" means any facility that is licensed by the Office of Licensure and Certification pursuant to Chapter 400 391, F.S., and which undertakes through its ownership or management to furnish, for a portion of the day, basic services to three or more medically complex children who are not related to the owner or operator by blood, marriage, or adoption and who require such services.

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

(220)(224) "Primary care" means comprehensive, coordinated, and readily-accessible medical care, furnished at the recipient's first point of contact with the health care system, including health promotion and maintenance, treatment of illness and injury, early detection of disease and referral to specialists when appropriate.

(221)(225) "Primary care physician" means a Medicaid-participating or prepaid health plan-affiliated physician practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, or other specialty approved by the Agency department, who furnishes primary care and patient management services to a recipient.

(222)(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

(223)(227) "Private duty nursing" means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely furnished by the nursing staff of the hospital or nursing facility.

(224)(228) "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds thereon and includes insurance payable by reason of loss or damage to the collateral or proceeds. Money, checks, deposit accounts, and the like are "cash proceeds." All other proceeds are "Manchus proceeds."

(225)(229) "Professional records" sSee "Medical records."

(226)(230) "Prosthetic device" or "prosthetic" means a device or appliance to replace all or part of the function of a permanently inoperative or malfunctioning body organ.

(227)(231) "Protocols" are written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem, or implementing a plan of medical, nursing, psychosocial, developmental, and educational services.

(228)(232) "Provider" means a person or entity that has been approved for enrollment and has a Medicaid provider agreement contract in effect with the <u>Agency department</u>.

(229)(233) "Provider agreement" or "Provider agreement contract" means a contract between the Agency department and a provider for the furnishing of medical or allied care, goods, or services to recipients.

(230)(234) "Provider <u>h</u>Handbook" or "Provider <u>m</u>Manual" means a document that provides information to a Medicaid provider regarding recipient eligibility, claims submission and processing, provider participation, covered care, goods, or services and limitations, procedure codes and fees, and other matters related to Medicaid program participation.

(231)(235) "Provider service utilization profile" means a report concerning Medicaid care, goods, or services billed by or reimbursed to a provider in a given time period, listing such items as number of goods or services, procedure codes, descriptions of goods or services, number of goods or services furnished per recipient, cost per item or service, and cost per recipient.

(232)(236) "Psychiatric services" means services included in the branch of medicine that treats mental and neurotic disorders and the pathologic or psychopathologic changes associated with them.

(233)(237) "Psychiatrist" means a physician who is certified as a psychiatrist by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(234)(238) "Public Public Assistance Specialist (PAS)" means a department staff member responsible for determining eligibility for some categories of recipients.

(235)(239) "Qualified Intellectual Disability Professional (QIDP) mental retardation professional (QMRP)" means an individual who meets the requirements as defined in 42 CFR Section 483.430 s. 442.401.

(236)(240) "Quality assurance" means the process of assuring that the delivery of Medicaid care, goods, or services is appropriate, timely, accessible, available, and medically necessary.

(237) "Quality Improvement Organization (QIO)" entity is designated through the Centers for Medicare and Medicaid Services to perform utilization review services and to monitor the appropriateness of care provided to individuals through a state Medicaid program.

(238)<del>(241)</del> "Recertification" means renewal of certification.

(239)(242) "Recipient" or "Medicaid recipient" means any individual whom the Agency, Department of Children and <u>Families Family Services</u> or the Social Security Administration on behalf of the Department of Children and <u>Families Family Services</u> determines is eligible, pursuant to federal and state law, to receive medical or

allied care, goods, or services for which the Agency may make payments under the Medicaid program and is enrolled in the Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

(240)(243) "Records". See "Business Records," "Medicaid-related records," and "Medical records."

(241)(244) "Records for audit" means those records, business records, medical records, professional records, documents and files, on whatever media, that the Agency department finds necessary in order to determine the correctness and propriety of cost reports or to determine whether Medicaid payments are or were due and the amounts thereof. Such records must be furnished by providers in accordance with the provisions of section ss. 1128(b) and 1902(p) of the federal Social Security Act. Also see "Audit," "Business records," "Medicaid-related records," and "Medicaid records."

(242)(245) "Recoupment" means the process by which the Agency department recovers an overpayment or inappropriate payment from a Medicaid provider.

(243)(246) "Registered nurse (RN)" means a graduate of an approved formal program of study in professional nursing who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 464, F.S., or the applicable laws of the state in which the service is furnished.

(244)(247) "Resident" means an applicant or recipient who resides in an institutional care facility.

(245)(248) "Resident record" means any file or record in the name of an individual applicant or recipient that is maintained in the facility where he resides or has resided.

(246)(249) "Respiratory therapist" means an individual certified under the provisions of Chapter 468, F.S., or the applicable laws of the state in which the service is furnished, and who is a graduate of a program approved by the American Association for Respiratory Care.

(247)(250) "Respiratory therapy" means therapy related to conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system.

(248)(251) "Responsible physician" means a licensed physician delegated by the supervising physician as responsible for the care, goods, or services furnished by a physician's assistant in the absence of the supervising physician.

(249)(252) "Risk" or "underwriting risk" means the potential for loss that is assumed by a contractor and that may arise because the cost of providing care, goods, or services may exceed the capitation or other payment made by the Agency department to the contractor under terms of the contract.

(250)(253) "Routine" refers to medications, treatments, care, goods, or services furnished in accordance with an established or predetermined schedule and performed for individuals whose medical needs are stabilized or chronic.

(251)(254) "Rural health clinic" means a clinic primarily engaged in providing outpatient health care and related services and that is certified by and participating in Medicare and that:

(a) is located in an area designated by the United States Bureau of the Census as rural and designated by the Secretary of Health and Human Services as having a shortage of personal health services or primary medical eare manpower; or

(b) Qualifies pursuant to the grandfather provision in accordance with 42 CFR 491.5.

(252)(255) "Sample" means a subset of the units of a population taken and used in accordance with generally accepted statistical methods.

(253)(256) "Screen" or "screening" or "screening services" means assessment of a recipients' physical or mental condition to determine evidence or indications of problems and need for further evaluation or services.

(254)(257) "Section 504 of the Rehabilitation Act of 1973" means the federal law that, along with the Americans with Disabilities Act, prohibits discrimination on the basis of disability.

(255)(258) "Service" includes any diagnostic or treatment procedures or other medical or allied care claimed to have been furnished to a recipient and listed in an itemized claim for payment, or, in the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim. Also see "Medicaid services" and "Covered services."

(256)(259) "Service area" with respect to prepaid health plans means the designated geographical area within which the contractor is authorized by contract to furnish covered services to HMO enrollees and within which the enrollees reside.

(257)(260) "Service authorization" means the approval required from the designated authority for reimbursement for certain Medicaid services.

(258)(261) "Service limit" or "service limitation" means the maximum amount, duration, or scope of a Medicaid covered service.

(259)(262) "Service limitation period" means the period of time that is used in the calculation and application of service limitations.

(260)(263) "Service site(s)" with respect to prepaid health plans means the location(s) designated by a contractor at which enrollees HMO members receive services covered under terms of the contract.

(261)(264) "Service utilization reports" or "service utilization data" are reports indicating Medicaid and other services utilized by recipients, referral reports by <u>Agency</u> department staff regarding the recipient's utilization of his Medicaid Identification Card (MIC) and services locally, and referral reports from the Medicaid Drug Utilization Review (DUR) program.

(262)(265) "Simple mistake" means an inadvertent or unintentional error.

(263)(266) "Skilled care resident" means a Medicaid application or recipient who requires skilled nursing services as defined in Rule 59G-4.290, F.A.C., and who resides in a facility licensed to furnish such services.

(264)(267) "Solicitation" means illegal solicitation. Also see "Bribe, Kickback, or Illegal solicitation."

(265)(268) "Specialist" means a physician whose practice is limited to a particular branch of medicine or surgery, including one who, by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice.

(266)(269) "Speech pathologist" or "speech therapist" means an individual who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 468, F.S., or the applicable laws of the state in which the service is furnished, and who is certified by the American Speech, Hearing, and Language Association.

(267)(270) "Speech therapy" means the identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma-related maxillofacial anomalies, or neurological conditions that affect oral motor functions and includes the evaluation and treatment of problems related to oral motor dysfunction.

(268)(271) "State-defined health maintenance organization (SDHMO)" means an entity certified by the <u>Agency</u> department and to the <u>Health Care Financing Administration</u> as meeting the Medicaid State Plan definition of a Medicaid health maintenance organization.

(269)(272) "State mental hospital" means a state owned or operated institutional care facility that furnishes inpatient psychiatric hospital services to individuals with a primary diagnosis of mental illness.

(270)(273) "Sterilization" means any medical or surgical procedure performed for the purpose of rendering a person permanently incapable of reproducing.

(271)(274) "Subcontract" means a written agreement entered into by a contractor for provision of services on its behalf.

(272)(275) "Subcontractor" means any person to which a provider or contractor has contracted or delegated some of its management functions or its responsibilities for providing medical or allied care, goods, or services; or its claiming or claims preparation or processing functions or responsibilities.

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

(274)(277) "Supplies and appliances" are items necessary for use by a patient during the course of an illness or injury. Also see "Durable medical equipment," "Goods," and "Medical supplies."

(275)(278) "Surgeon" means a physician who is certified or meets the requirements for certification by the American Board of Surgery or the American Osteopathic Association.

(276)(279) "Suspension" means exclusion by the <u>Agency department</u> of a provider from further participation in the Medicaid program for a specific period of 1 year or less, after which the provider must apply to the <u>Agency department</u> for re-enrollment. Also see "Termination."

(277)(280) "Swing bed" means bed in a rural hospital licensed pursuant to Chapter 395, F.S., that can also be used for skilled or intermediate nursing care services.

(278)(281) "Target group" means the specific population identified in a state plan amendment to receive targeted case management services from providers meeting specific eligibility requirements. Targeting may be done by age, type or degree of disability, illness or condition, or any other identifiable characteristic or combination thereof.

(279)(282) "Targeted case management" means those activities that assist specified target groups of recipients in gaining and coordinating access to necessary care and services appropriate to the needs of an individual.

(280)(283) "Terminal" or "terminally ill" means a medical prognosis, as certified by a physician, of a life expectancy of six (6) months or less.

(281)(284) "Termination" means exclusion by the <u>Agency</u> department of a provider from further participation in the Medicaid program for a period of more than 1 year up to 20 years, after which the provider must apply to the <u>Agency</u> department for re-enrollment. Also see "Suspension."

(282)(285) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid.

(283)(286) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the Agency department, for any Medicaid-covered injury, illness, or other medical or allied care, goods, or services, including costs of medical or allied care, goods, or services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient, unless available under terms of the policy to pay medical expenses prior to death. The term includes, without limitation, collateral as defined in this section, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance or personal injury protection coverage, medical benefits under workers' compensation, and any obligation under law or equity to furnish medical support.

(284)(287) "Third party payment" means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services.

(285)(288) "Title VI of the Civil Rights Act of 1964" means the federal law that prohibits discrimination in the provision of services to recipients on the basis of race, color, creed, or national origin.

(286)(289) "Title XVIII" means the sections of the federal Social Security Act, 42 U.S.C., section- 1395 et seq., and regulations thereunder, that authorize the Medicare program.

(287)(290) "Title XIX" means the sections of the federal Social Security Act, 42 U.S.C, section- 1396 et seq., and regulations thereunder, that authorize the Medicaid program.

(288)(291) "Transplant center" means a hospital unit that is approved by the United Network for Organ Sharing (UNOS) to furnish transplantation and other medical and surgical specialty services required for the care of organ tissue transplant patients.

(289)(292) "Transportation" means an appropriate means of conveyance furnished to a recipient to obtain Medicaid or other authorized services.

(290)(293) "Treating provider" means an individual provider who personally renders Medicaid services, or assumes responsibility for rendering Medicaid services through personal supervision, on behalf of a Medicaid group provider. Services furnished by a treating provider are billed by and payment is remitted to the group provider.

(291)<del>(294)</del> "Treatment plan" sSee "Active treatment plan" and "Plan of care."

(292)(295) "Treatment services" means corrective, therapeutic, or restorative services furnished as a result of a diagnosis identified during a screening.

(293)(296) "Treatment team" means all professional staff members involved in providing services to a client.

(294)(297) "Unclean claim" means a claim that has not been properly completed according to Medicaid's billing guidelines, including a claim that is not accompanied by the necessary documentation required by state law, federal law, or state administrative rule for payment. also see "Clean claim."

(295)(298) "Underutilization" means the failure by a recipient to obtain available and needed Medicaid services.

(296) "Usual and customary charge" means, for all providers except for pharmacy providers, the provider's most frequent price or fee accepted as full payment by the provider from the provider's non-Medicaid Florida customers.

For ease of calculation, the "usual and customary charge" shall be determined by the provider as of July 1 each year, and shall be the most frequent price or fee accepted as full payment by the provider from the provider's non-Medicaid Florida customers for the specific service in the prior year (July 1-June 30).

(299) "Utilization and Quality Control Peer Review Organization" means an entity that is designated by the Health Care Financing Administration as a peer review organization (PRO).

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

(298)(301) "Utilization review committee (URC)" means a committee composed of physicians, assisted by other professional personnel, that performs the utilization review function.

(299)(302) "Utilization review contractor" means an entity that is under contract with the <u>Agency department</u> to perform and monitor utilization review functions, which determine the appropriateness of payments for Medicaid services.

(300)(303) "Vendor" means an individual or entity that engages in the business of selling care, goods, services, or commodities.

(301)(304) "Visit" means a face-to-face contact between a health care practitioner and a recipient that takes place at a center, office, home, or other place of service.

(302)(305) "Void" means a negation of an original payment.

(303)(306) "Waiver case management" means the process of assisting recipients to gain access to needed waiver and other state plan services in addition to medical, social, educational, and other services without regard to the funding source of the service.

(304)(307) "Waiver plan of care" means a written individual plan developed by social and health care professionals that describes the services to be furnished, and specifies frequency and type of provider to furnish each service.

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