



We have the legal right of way.

MEDICAID: Glossary of Commonly Used Terms

Adverse benefit determination - a managed care plan's decision not to provide you services. This could be a (1) denial or limited authorization of a requested service; (2) reduction, suspension, or termination of services; (3) denial of payment for a service; (4) failure to provide services in a timely manner; (5) failure to act within the resolution time frames; or (6) denial of a request to dispute a financial liability, such as cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities.

Appeal - a request to have a decision about your Medicaid services reviewed by someone with more authority over a situation. For example, an agency or managed care plan may tell you it is going to reduce or end your aide or nursing services, or it may deny your request for services or equipment (like a wheelchair or other adaptive device). You generally have the right to appeal these decisions.

Appeal resolution - the decision made by the managed care plan about an appeal

Authorization period - the length of time that your managed care plan or the Department of Medicaid agrees to cover services that require prior authorization. If you will need to continue these services after the authorization period ends, you will usually have to submit a new prior authorization request.

Continuation of benefits (also called continuing assistance or continued services) - the ability to keep your current services until a final decision is made, if you file an appeal request within the right amount of time, with some exceptions

Coordinated Services Program - a health and safety program that protects members who use more services than they were expected to use. Members in a Coordinated Services Program are assigned to and must use designated providers for their health care services, including prescription medication. You may be in this program if you receive controlled substances from multiple

pharmacies and/or prescribers. If you are not sure whether you are in this program, contact your managed care plan or the Medicaid hotline at 800-324-8680. More information is available on the Ohio Department of Medicaid website: <https://www.ohiomh.com/resources/coordinatedservicesprogramfaq>.

Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) - a child health program in Medicaid designed to meet the physical, mental and developmental health needs of children younger than 21. In Ohio, the EPSDT program is called Healthchek.

Expedited appeal - an appeal that is decided/resolved in a shorter timeframe

Fee-for-service (FFS) - a traditional method of paying for medical services in which providers are paid for each service they provide. The provider usually submits bills to the Ohio Department of Medicaid for reimbursement. People who receive fee-for-service medical services do not have managed care plans.

Good cause - a reason that explains why you are not able to meet a deadline or attend a hearing. This must be a death in the immediate family, sudden illness or injury of the individual or a member of the individual's immediate family, or other circumstances that reasonably prevented attendance at a state hearing.

Grievance - a complaint about the managed care plan, a practitioner or any matter other than an action taken by the plan. Grievances can include issues with the quality of care or services provided; aspects of interpersonal relationships, such as rudeness of a provider or employee; or failure to respect a member's rights.

Managed care plans - private health insurance companies that are contracted with the state of Ohio and are responsible for arranging and covering all of the health care services offered through traditional Medicaid for their members

Medically necessary - Medical necessity is a fundamental concept underlying the Medicaid program. The definition depends on the program:

- A. **Medical necessity for individuals covered by early and periodic screening, diagnosis and treatment (EPSDT)** is defined as procedures, items or services that prevent, diagnose, evaluate, correct, ameliorate or treat an adverse health condition, such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment or developmental disability.
- B. **Medical necessity for individuals not covered by EPSDT** is defined as procedures, items or services that prevent, diagnose, evaluate or treat an adverse health condition, such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment or developmental

disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

Notice - a letter that explains what action was taken about your services, the reasons, and your right to appeal the decision.

Notify - to inform someone about something, usually in an official or formal way. When managed care plans or other agencies make decisions about your Medicaid services, they must sometimes give you information in writing. The letter is called a notice.

Prior authorization - a process that your doctor or provider uses to get approval for services before you can receive them

Provider - a person or facility that offers health care, such as a doctor, pharmacy, dentist, clinic, hospital, physical therapist, nurse or aide

Reduced - made smaller or less in amount

Restored - returned, reinstated or put back

Require - need for a particular purpose

State hearing process - the official way the state of Ohio allows people to challenge decisions made about their Medicaid services through appeal. A state hearing is a meeting with you, someone from the local agency, and a hearing officer from the Ohio Department of Job and Family Services (ODJFS). The meeting could be on the phone or in person. The person from the local agency will explain the action it has taken or wants to take on your case. Then, you will have a chance to say why you think the action is wrong. The hearing officer will listen to you and to the local agency and may ask questions to help bring out all the facts. The hearing officer will review the facts presented at the hearing and recommend a decision based on whether or not the rules were correctly applied in your case.

Waiver - Medicaid money that is used to allow people with disabilities and chronic conditions to receive care in their homes and communities instead of in long-term care facilities, hospitals or intermediate care facilities.

Waiver case management agency - the agency that assesses your needs, helps develop a person-centered care plan for you and helps coordinate your waiver services