

State Program Integrity Assessment (SPIA)

GLOSSARY OF TERMS

1. **ABUSE:** Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care.
2. **ACCEPTED REFERRAL:** Referral of a potentially fraudulent Medicaid provider to the State's Medicaid Fraud Control Unit (MFCU) that is accepted by the MFCU.
3. **ADMINISTRATIVE ACTION:** Provider sanction, payment suspension or other action taken by the State against a Medicaid provider before a determination of Medicaid fraud, waste or abuse or overpayment has been made.
4. **ALGORITHM:** A set of well-defined rules or procedures for solving a problem in a finite number of steps.
5. **ARTIFICIAL INTEGELLIGENCE:** An algorithm or set of algorithms that can make decisions in a logical way.
6. **AUDIT:** An assessment, evaluation, inspection, or investigation of services rendered or items furnished by a Medicaid provider.
7. **AUDIT, COMPREHENSIVE:** Examinations of the adequacy, legality, and efficiency of the application of public funds. Such examinations involve not only individual fiscal transactions but also the financial management, internal controls, policies, and operating environments governing such transactions.
8. **AUDIT, COST REPORT:** An examination of financial transactions, accounts, and reports as they relate to the cost report submitted by a provider in order to evaluate the provider's compliance with applicable Medicaid laws, regulations, manual instructions, and directives and to verify the accuracy and applicability of the costs.
9. **AUDIT, DESK:** An audit that is wholly or principally carried out in the office(s) of the auditor.
10. **AUDIT, FIELD:** An audit that is carried out at the office(s) of the organization being audited or includes a substantial "on-site" component.

GLOSSARY OF TERMS

11. **AUDIT, FOCUSED:** A review of services rendered or items furnished by a Medicaid provider that is limited in scope to a specific set of services or items or particular inappropriate billing practices.
12. **AUDIT, PROVIDER SELF:** An audit that is carried out wholly or principally by the provider being audited.
13. **CASE:** An investigation by a Medicaid Program Integrity office, a Medicaid Fraud Control Unit, or other agency, to determine whether there has been a violation by a Medicaid provider of Medicaid laws, rules, or regulations or accepted standards.
14. **CIVIL MONEY PENALTIES:** Any penalty, fine, or other monetary sanction against individuals/entities for conduct that violates Federal and/or State statutes and regulations governing the Medicaid program.
15. **CLAIM:** A request for payment for services and benefits rendered by a Medicaid provider, also known as bills or invoices.
16. **COLLECTIONS:** Cash recovered in reimbursement of overpayments or other cash received as a result of Medicaid program integrity activities.
17. **COMPREHENSIVE MANAGED CARE:** Managed care plans (e.g., Health Maintenance Organizations, Preferred Provider Organizations) that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract.
18. **COST AVOIDANCE:** An action or intervention that reduces or eliminates a cost or outlay that would have occurred if not for that action or intervention.
19. **COST REPORT:** Report required from providers on an annual basis in order to make a proper determination of reimbursement rate under the Medicaid program based on the expenses incurred by the provider in the course of supplying services.
20. **CREDENTIALING:** Review procedures conducted for the purpose of determining whether a potential or existing provider meets certain standards that are a prerequisite for them to begin or continue participation in a given health care plan.

GLOSSARY OF TERMS

21. **DATA MINING:** The analysis of large volumes of data maintained in databases or data warehouses using query tools, algorithms, and models to identify patterns, trends, and relationships or correlations among the data and to develop useful information for investigative and management purposes.
22. **DATA REPOSITORY PLATFORM:** A logical partitioning of data where multiple databases that apply to specific applications or sets of applications reside. A central place where data is stored and maintained.
23. **DATA WAREHOUSE:** A relational database designed for query and analysis, rather than for transaction processing. It usually contains historical data derived from transaction data, but can include data from other sources. It separates analysis workload from transaction workload and enables an organization to consolidate data from several sources.
24. **DECISION SUPPORT SYSTEMS (DSS):** A systematic collection of data, techniques, and supporting software and hardware by which an organization gathers and interprets relevant information from business and the environment and turns it into a basis for making management decisions.
25. **DETECTION:** Activities such as data mining, auditing, surveillance utilization and reviews or other methods, aimed at identifying possible fraud, waste, and abuse in the Medicaid program.
26. **DISTINCT PROGRAM INTEGRITY MODEL:** Organizational structure in which a distinct Medicaid program integrity unit exists within the State. Medicaid Integrity activities such as prevention, detection, audit and investigation lie wholly within the State Medicaid Agency but are not necessarily centralized in a Medicaid “Program Integrity Unit.”
27. **DOLLARS IDENTIFIED FOR RECOVERY:** Represents the dollar amount of claims inappropriately paid as identified by data mining, audit, surveillance utilization review or other methods.
28. **DOLLARS RECOVERED:** Represents total dollar amount of overpayments actually recovered by the State (as opposed to dollars identified or an agreement by the provider to refund the program).

GLOSSARY OF TERMS

- 29. EDITS:** “Front end” reviews or controls in the Medicaid Management Information Systems (MMIS) that examine the information in each claim in relation to certain Medicaid policies and to other claims, and cause the claim to be paid, pended, or denied.
- 30. ENCOUNTER DATA:** Data related to the services and items received by a Medicaid recipient in an encounter with or visit to a Medicaid provider, whether on a fee-for-service or managed care basis. Also referred to as "shadow claims".
- 31. ENROLLMENT:** The process of admitting (or not admitting) a prospective provider or recipient into the Medicaid program or a component of the program, such as managed care.
- 32. EXCLUDED INDIVIDUALS OR ENTITIES:** Individuals or entities that have been placed in non-eligible participant status under Medicare, Medicaid and other Federal or State health care programs. Exclusions may occur due to OIG sanctions, failure to renew license or certification registration, revocation of professional license or certification, or termination by the State Medicaid Agency.
- 33. EXCLUDED PARTIES LIST SYSTEM (EPLS):** An electronic, web-based system maintained by the General Services Administration (GSA) that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. Can be found at <http://www.epls.gov>.
- 34. EXPENDITURE:** Refers to funds spent as reported by the State.
- 35. EXTRAPOLATION:** The process of predicting a future cost (or other measure) using current data or results from the past.
- 36. FEE-FOR-SERVICE (FFS):** Traditional method of payment for medical services where payment is made to providers for each service rendered.
- 37. FRAUD:** 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. Includes any act that constitutes fraud under applicable Federal or State law.

GLOSSARY OF TERMS

- 38. FRAUD AND ABUSE DETECTION SYSTEM (FADS):** A computer-based system employing various analytical software and methodologies to detect inappropriate billing or fraud by Medicaid providers.
- 39. FRAUD INVESTIGATION:** An investigation of possible fraud that is conducted by State Medicaid Fraud Control Units or other investigative entities based on tips and referrals from providers, recipients, and other governmental agencies.
- 40. FRAUD INVESTIGATIONS DATABASE (FID):** A comprehensive, nationwide system devoted to Medicare & Medicaid fraud and abuse and information-sharing process among government agencies, the FBI, DOJ, State MFCUs, Postal Inspectors' offices, Medicare contractors, and other program integrity stakeholders.
- 41. HEALTH CARE INTEGRITY PROTECTION DATA BANK (HIPDB):** A national health care fraud and abuse data collection program for the reporting and disclosing of certain adverse actions taken against health care providers, suppliers and practitioners and for maintaining a database of final adverse actions taken against health care providers, suppliers and practitioners.
- 42. HYBRID MODEL:** Organizational structure within a State in which the Medicaid Integrity activities are distributed across multiple bureaus, offices, or units throughout the State Medicaid Agency. There is no distinct Program Integrity unit.
- 43. INAPPROPRIATE PAYMENT:** Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirement.
- 44. INSPECTOR GENERAL (IG) MODEL:** Organizational structure within a State in which a centralized Office of Inspector General (or equivalent) is independent of the Medicaid program. The IG unit conducts and supervises all prevention, detection, audit, and investigation efforts for all Medicaid payers (e.g., Medicaid program, mental health, alcohol/substance abuse, long term care services).
- 45. INVESTIGATION:** The analysis and gathering of evidence to support findings of suspected cases of fraud, waste and abuse by Medicaid providers.

GLOSSARY OF TERMS

- 46. INVOLUNTARY DIS-ENROLLMENT:** Administration action by a State to terminate a provider's participation in the Medicaid program due to noncompliance with Medicaid rules, regulations, payment policy and/or quality of care standards.
- 47. JUDGMENT:** A court's final determination of the rights and obligations of the parties in a case.
- 48. LIST OF EXCLUDED INDIVIDUALS AND ENTITIES (LEIE):** List maintained by OIG of individuals and business excluded from participating in Federally-funded health care programs available at <http://www.oig.hhs.gov/fraud/exclusions.html>.
- 49. MANAGED CARE:** A comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider.
- 50. MANAGED CARE ORGANIZATION (MCO):** An organization or entity that has a comprehensive risk contract under Medicaid to provide benefits to Medicaid recipients.
- 51. MANAGED CARE OVERSIGHT:** Management and/or supervision of managed care organizations to ensure compliance with Medicaid rules, regulations, and policies.
- 52. MEDICAID FRAUD CONTROL UNITS (MFCUs):** A functional entity, usually located in the offices of the State Attorney General, or other Department designated by the State, that investigates and prosecutes Medicaid fraud cases. Operates under a Memorandum of Understanding with the State Medicaid Agency and is subject to oversight by the DHHS' OIG.
- 53. MEDICAID INTEGRITY:** Planning, prevention, detection, and investigation/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, or abuse.

GLOSSARY OF TERMS

- 54. MEDICAID INTEGRITY PROGRAM:** Program established by the Deficit Reduction Act (DRA) of 2005 that provides the Centers for Medicare & Medicaid Services (CMS) with increased resources to prevent, identify, and recover inappropriate Medicaid payments. The two main operational responsibilities under the program are: 1) reviewing the actions of those furnishing items or providing services under Medicaid and 2) providing effective support and assistance to States to combat Medicaid fraud, waste, and abuse.
- 55. MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS):** An automated claims processing and information retrieval system required under the Medicaid program that produces service utilization and management information.
- 56. NATIONAL PRACTITIONER'S DATABANK :** A computerized data bank maintained by the federal government that contains information on physicians who have paid malpractice claims or against whom certain disciplinary actions have been taken.
- 57. OFFSET:** Withholding of funds from future provider payments to recover overpayments identified through Medicaid program integrity activities.
- 58. OVERPAYMENT:** Any payment made to a Medicaid provider in excess of the payment to which the provider was entitled under State or federal laws and regulations.
- 59. PARTICIPATING PROVIDER:** Provider that actively bills the Medicaid program.
- 60. PREDICTIVE MODEL:** A mathematical or statistical method for analyzing a body of data and predicting or forecasting future results or behavior.
- 61. PREVENTION:** Activities to minimize the risk of fraud, waste, or abuse entering the payment system and activities used to educate Medicaid program staff and providers.
- 62. PRIMARY CARE CASE MANAGEMENT (PCCM):** The health care management activities of a provider that contracts with the State to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services reimbursed on a FFS basis.

GLOSSARY OF TERMS

- 63. PRIOR AUTHORIZATION:** A formal process by which, as a precondition for provider reimbursement, providers or recipients must obtain approval for certain medical services, equipment, or supplies (based on medical necessity) before the services are provided to recipients.
- 64. PROPRIETARY DATABASE:** A copyrighted database accessible by subscription.
- 65. PROVIDER:** Any person or entity enrolled in the Medicaid program that provides services and/or furnishes items that are billable under Medicaid.
- 66. PROVIDER EDUCATION/COMMUNICATIONS:** Activities designed to educate and communicate with providers about Medicaid rules, regulations, and policies to ensure quality of care and payment integrity.
- 67. PROVIDER PAYMENT SUSPENSION:** The withholding of payment by a State Medicaid Agency to a provider or supplier before a determination of the amount of the overpayment exists.
- 68. RAMS II:** An advanced version of the mainframe Surveillance and Utilization Review Subsystem (SURS) system developed by a MMIS contractor.
- 69. RECIPIENT:** An individual who receives benefits under the Medicaid program.
- 70. RECOVERY:** Collections and offsets received from providers as a result of overpayments or other State program integrity activities. Does not include third party liability (TPL) or prior authorizations.
- 71. REFERRAL:** Information on potential provider fraud that is forwarded from the State Medicaid Agency to the Medicaid Fraud Control Unit (MFCU) or other State or federal investigative agency.
- 72. RETURN ON INVESTMENT (ROI):** Savings/collections attributable to Medicaid program integrity efforts per dollar invested.
- 73. SAMPLING:** Random selection of a subset of a population.

GLOSSARY OF TERMS

- 74. SANCTION:** A penalty assessed on a Medicaid provider for a violation or violations of Medicaid laws, rules, regulations, or policies. May be in the form of a fine, suspension, termination, exclusion, civil monetary penalty, requirement for correction action, or other remedy/action.
- 75. SETTLEMENT:** A negotiated agreement to collect identified overpayments from a Medicaid provider.
- 76. SINGLE STATE AGENCY (SSA):** The single agency within the State responsible for the administration of the state Medicaid plan on behalf of the State.
- 77. STANDARD OPERATING PROCEDURE:** An established procedure to be followed in a given situation.
- 78. STATISTICAL ANALYSIS:** Process of examining data to draw conclusions or make inferences about a population based on a sample or subset of the population.
- 79. STRATEGIC PLAN:** A document used by an organization to align its policies and budget structure with organizational priorities, missions, and objectives. Should include a mission statement, a description of the agency's long-term goals and objectives, and strategies or means the agency plans to use to achieve these goals and objectives. May also identify external factors that could affect achievement of long-term goals.
- 80. SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (SURS):** A component of the Medicaid Management Information Systems designed to process information on medical and health care services to assist Medicaid program managers in identifying possible fraud and abuse by providers and Medicaid recipients. State SURS staffs perform data mining and other research for post-pay utilization review of providers and recipients in order to identify questionable patterns of service delivery and utilization.
- 81. SURS I:** The early version of the mainframe-based SURS system developed in the late 1970's/early 1980's.
- 82. SURS II:** An updated version of the mainframe-based SURS-I system.

GLOSSARY OF TERMS

- 83. SURS, ADVANCED:** Advanced versions of the mainframe-based SURS-I and SURS-II systems.
- 84. SURS, PC-BASED:** A client-server, PC-based system that can be operated through a dedicated network and that provides a place to store extensive SURS data, process SURS runs, and store reports. More user-friendly than traditional mainframe SURS (i.e., uses “point-and-click” technology and is capable of performing several functions at the same time) and allows users to perform analyses from desktops and receive relatively quick results.
- 85. SURS, CS-BASED:** An advanced version of the PC-based SURS system.
- 86. TERMINATED PROVIDER:** A provider who has been terminated from Medicaid program participation by the State Medicaid Agency due to program integrity concerns.
- 87. THIRD PARTY LIABILITY (TPL):** The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary.
- 88. TIP:** Complaint of suspected Medicaid provider fraud, waste or abuse.
- 89. TOTAL RECOVERIES:** Dollars recovered from overpayments, settlements/judgments, and other collections (excluding TPL and prior authorization).
- 90. WITHDRAWN PROVIDER:** A provider who has withdrawn from participation in the Medicaid program.