

GLOSSARY

Advance Directives – legal documents about health care decisions used only when a patient loses the ability to make his/her own decisions or when the patient is injured to the extent that he/she is unable to express his/her wishes about medical care.

Affiliated Hospital – a contracted hospital that provides comprehensive hospital services to Members enrolled in the Program.

Affiliated Physician – a contracted licensed doctor of medicine or osteopathy who provides health services to Members enrolled in the Program.

Ambulatory Surgery – any procedure that can be done on an outpatient basis. If complications arise that necessitate admission, ambulatory surgeries can be changed to and authorized for an inpatient hospital stay.

Case Management – a process to foster comprehensive, collaborative, inter-disciplinary patient care planning that includes the physician, Member and the Interdisciplinary Team to promote quality and cost-effective health care.

Centers for Medicare and Medicaid Services (CMS) – Centers for Medicare & Medicaid Services, formerly known as HCFA. A federal agency that is part of the U.S. Department of Health and Human Services. CMS is responsible for administering Medicare and contracts with PHP for its Medicare Advantage, CMA and Prescription Drug Plans (PDP).

Clean Claim – a claim for reimbursement submitted to PHP by a Provider on a standard form, that includes the following: (1) date on which the Covered Service(s) were performed (2) description of the Covered Service(s) performed (3) listing of Provider as the Provider of services (4) listing of Provider's billed charges and any other completed elements required to process it fully.

Community Health Partnership – also referred to as “Program”. A Program of Partnership Health Plan, Inc. (PHP) which provides acute, primary and/or long term care benefits to enrolled beneficiaries eligible for the Wisconsin Medical Assistance Program (WMAP) and/or Medicare.

Community Health Partnership, Inc. – also referred to as “CHP”. A private nonprofit, nonstock section 501 (c) (3) Wisconsin corporation and the sole Member of PHP, which is under contract with PHP to provide all administrative services for PHP and Program.

Covered Services – the medical care, services, supplies and equipment that are covered by PHP for which a Member is eligible under the terms of his/her Enrollment Agreement. Only services that are deemed medically and/or socially necessary are provided or approved by the Member's PCP, Interdisciplinary Team, or designee.

Culturally Competent Health Care – demonstrated awareness and integration of health-related benefits and cultural values, disease incidence and prevalence, and the appropriate management and prevention of disease as it relates to the presenting population's culture.

Department of Health and Family Services – also referred to as the “Department” or “DHFS.” The state agency that operates the Wisconsin Medical Assistance Program (WMAP).

Emergency Medical Condition – a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child)
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Continuance of severe pain

Emergency Services – services provided after the sudden onset of an emergency medical condition.

Evidence of Coverage (EOC) – the document that PHP issues to Members enrolled in its Program which describes the covered services that the Member is entitled to receive.

Inpatient Status – a hospital stay longer than 24 hours ordered by the admitting physician.

Individualized Service Plan – also referred to as “ISP”. An individual plan containing measurable goals specifying the treatment, strategies or services as well as the person, provider, or community organization responsible for providing the services. Member goals and preferences must be identified in the ISP.

Interdisciplinary Team – PHP case management Team consisting of a Registered Nurse, Social Services Coordinator and a Team Assistant. At enrollment, each Member is assigned to an Interdisciplinary Team, which along with a Nurse Practitioner, PCP, Member and the family, develops a customized ISP. The ultimate goal of the Interdisciplinary Team is to maintain independence and the health status of the Member.

Long Term Care Functional Screen – a questionnaire completed by the Member upon enrollment. It provides information for care management planning based on the Member’s current health status. The questionnaire is used to assist in identifying Members with serious and complex health conditions.

Maintenance or Supportive Care – services provided to a Member after the acute phase of an illness or injury has passed and maximum therapeutic benefit has occurred. These services are provided to a Member whose recovery has reached a plateau, slowed or ceased, where only minimum rehabilitative gains can be demonstrated with continued care. PHP makes the determination of what constitutes maintenance or supportive care after careful review of the Member’s case history and treatment plan submitted by a health care Provider.

Medicaid – also known as MA “Medical Assistance” and “WMAP”. The Program operated by the Wisconsin DHFS under the Social Security Act, Chapter 49, Wisconsin Statutes and under related State and Federal rules and regulations.

Medical Director – a PHP employed physician who, among other duties, monitors and reviews the utilization of covered services by Members.

Medically Necessary – those services that are required to prevent, identify or treat a Member’s illness, injury or disability and meet the following standards. Services that are:

1. Consistent with the Member’s symptoms or with prevention, diagnosis or treatment of the Member’s illness, injury or disability
2. Provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided
3. Appropriate with regard to generally accepted standards of medical practice
4. Not medically contraindicated with regard to the Member’s diagnosis, symptoms or other medically necessary services being provided to the Member
5. Proven medical value or usefulness and is not experimental in nature
6. Not duplicative with respect to other services being provided to the Member
7. Not solely for the convenience of the Member, the Member’s family or a Provider
8. The most appropriate supply or level of service that can safely and effectively be provided to the Member

Medicare – the federal health insurance program, operated by CMS, for: people 65 years of age or older, certain younger people with disabilities and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Member – an individual entitled to receive health care services under the terms of PHP’s Evidence of Coverage. The Member has enrolled in the Program voluntarily, and the Member’s enrollment has been confirmed by CMS and DHFS. Also a person who is eligible for enrollment in Program having been determined a Medicaid recipient and certified at a nursing home level of care. NOTE: A Member may also receive Medicare benefits under Parts A and B.

MetaStar/Quality Improvement Organization – a group of doctors and health professionals in the state who review medical care and handle certain types of complaints from patients with Medicare. “**QIO**” - stands for **Q**uality **I**mprovement **O**rganization. A QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In Wisconsin, the QIO is called MetaStar. You can contact MetaStar at 2909 Landmark Place, Madison, WI 53713, 1-608-274-1940 or toll free at 1-800-362-2320.

Non-Plan Providers (NPP) – health and long-term support Providers who are not contracted with PHP to provide services or supplies to enrolled Members. Services received from Non-Plan Providers are limited to emergency or urgently needed services, out-of area renal dialysis services and care that has been prior authorized for payment by PHP.

Notification – verbal or written approval provided by PHP prior to the care or services to Member.

Observation Status – a short-term hospital stay of less than 24 hours, classified as outpatient for the purpose of evaluation or minimal treatment as determined by the admitting physician.

Office of the Commissioner of Insurance (OCI) - agency that ensures insurance industries responsibly and adequately meet Wisconsin laws and rules while informing and protecting the public and responding to its insurance needs.

Out-Of-Area Services – services provided outside of the geographic area designated as the PHP service area. Out-of-area services covered by PHP are limited to urgently needed and emergency services.

Outpatient – utilization of ambulatory/ancillary service departments for diagnosis and treatment. “Partial hospitalization” is a structured program of active treatment that is more intense than the care received in the doctor’s or therapist’s office and is an alternative to inpatient hospitalization.

Partnership Health Plan, Inc. – also referred to as “PHP”. A private nonprofit, nonstock, section 501 (c)(3) corporation and Wisconsin licensed HMO which has contracts with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (“CMS”) to operate as a Medicare Advantage – Prescription Drug plan (MA-PD) and with the Wisconsin Department of Health and Family Services (“DHFS”) to offer Program in approved Wisconsin counties.

Partnership Health Plan, Inc. Provider Agreement – the contract between PHP and a health care Provider to provide health care services to PHP Members.

Plan Provider – a contracted health care or long-term support provider that provides or arranges for health or long-term care services for Members enrolled in PHP.

Primary Care Physician (PCP) - a physician licensed in the State of Wisconsin who has entered a contract with PHP to provide and coordinate care to Members, including those working at his or her direction, such as physician assistants, nurse practitioners or other licensed physicians, if such persons have been identified to PHP.

Prior Authorization or Preservice Determination – the process of obtaining authorization for payment of specific services and procedures prior to the service or procedure being performed.

Service Area – the geographical area in which PHP is approved for enrolling Members.

Target Length Of Stay (TLOS) – communicated during the inpatient admission authorization process. The TLOS is based on actuarial criteria and input from PHP’s Medical Director, if necessary.

Urgently Needed Care – services required in order to prevent serious deterioration of a Member’s health due to unforeseen illness or injury. Urgent care is a covered benefit even if the Member is outside the PHP service area. If the Member is within the service area, urgent care may be provided by a Non-Plan Provider under unusual circumstances.

Variance Days – inpatient hospital days that are in excess of the TLOS for the admitting diagnosis.