

**Florida Medicaid Management
Information System/
Decision Support System/
Fiscal Agent Operations**

**Operational File Maintenance
Procedures Manual**

Version 17.0

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Document Information Page

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Amendment History Page

Summary of Change

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Version 1.0	October 5, 2007	Melissa Gonzales	Approved document
Version 2.0	February 20, 2009	Melissa Gonzales	Updates based on internal review
Version 3.0	July 24, 2009	Kori Ricketts	Updates based on operations review
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Version 9.0	August 17, 2010	Kori Ricketts	Updates based on MFAO Letter #63593-10: <ul style="list-style-type: none">• Added detail to “Unborn Screening Process” on page 3-3; and• Edited instructions in “Keying the Request” on page 3-8.
Version 10.0	May 23, 2011	Cheryl Miller	The following changes resulted from a verbal request from Debbie Warfel and the Claims Department: <ul style="list-style-type: none">• Added “fax” to the methods by which a Prior Authorization is received in last paragraph at the beginning on page 4-1;• Added instructions for “Sorting PA Forms” on page 4-1;• Added list of items to be “Returned to State” at “Pre-approved Prior Authorizations” on page 4-2;• Edited third step in “Adding a Prior Authorization Request” on page 4-6;• Added sample reasons for return of a

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			<p>PA to “Adding a Prior Authorization Request” on page 4-6;</p> <ul style="list-style-type: none"> • Changed heading name from “To Process” to “Processing PA Updates” on page 4-6; • Removed Note following step 2 and added additional Notes after step 4 in “Processing PA Updates” on page 4-6; • Added detail and steps to “Verifying the Work” on page 4-7; • Changed heading name from “RTS/RTP Procedures” to “RTS/RTP Process” on page 4-8; and • Added detail to “Web Portal PAs” on page 4-8.
Version 11.0	July 18, 2011	Cheryl Miller	<p>Updates from MFAO Letter #67450-11:</p> <ul style="list-style-type: none"> • Added “with exception to the group of women described in Fundamental Rule 4.” to “Fundamental Rule 1: ” on page 4-4 “Fundamental Rule 2: ” on page 4-4, and “Fundamental Rule 3: (Effective April 19, 2005) ” on page 4-4; • Added “Fundamental Rule 4: (June 24, 2011)” on page 4-4; • Added “Clarifying Rules” on page 4-5; and • Added content to the end of section for “Clarifying Rules” on page 4-5. • Edits from MFAO Letter #67712-11: • Corrected date in Example for “Fundamental Rule 4: (June 24, 2011) on page 5-5; and • Inserted “also” after “rule” in the new sentence “This clarifying rule pertains...” in section for “Clarifying Rules” on page 5-5.
Version 12.0	September 9, 2011	Cheryl Miller	<p>Updates resulting from MFAO Letter #67722- 11 and 67405-11:</p> <ul style="list-style-type: none"> • Deleted “These go to the supervisor for delivery to the State.” from “Pre-approved Prior Authorizations” on page 4-2; • Edited step 3 for “Adding a Prior Authorization Request” on page 4-6;

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			<ul style="list-style-type: none"> Removed “and the keyer has signed the PA” from first paragraph in “Verifying the Work” on page 4-7; Edited steps 2 through 3 for “Verifying the Work” on page 4-7; Added Note to item 8 in “CCMS Records” on page 4-9; and Added statement to item 8 in “CCMS Records” on page 4-3. <p>MFAO Letter #70882-12 approved version 12.0 without edits, therefore, the version date was not changed.</p>
Version 13.0	March 13, 2014	Cheryl Miller	<p>Updates resulting from routine maintenance: Various minor updates to verbiage throughout;</p> <ul style="list-style-type: none"> Deleted former section 2.4 “Audit Criteria File Maintenance”; Deleted former section 3.3 “Form CF-ES 2014”; Updates to the list in “Unborn Screening Process” on page 3-3; Updates to the list in “Keying the Request” on page 3-8; Updates to the list in “Verifying the Work” on page 3-9; Deleted former chapter 4 “Prior Authorizations(PA)”; Updates to the list in “Receiving FP Documents” on page 4-1; Updates to the list in “Screening Documents” on page 4-1; Updates to the list in “Recipient Panel” on page 4-2; and Updates to the list in “RTS Forms - Return to State Process” on page 4-4.
Version 13.1 Draft	March 8, 2017	Latoya Smith	<p>Updates resulting from routine maintenance:</p> <ul style="list-style-type: none"> Global replacement of the name and acronyms Medicaid Contract Management (MCM) with Medicaid Fiscal Agent Operations (MFAO); Global replacement of HMO with Managed Care (MC); Global removal of the term “Service Authorization”;

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Document Version #	Modified Date	Modified By	Section, Page(s) and Text Revised
			<p>Documents” on page 4-1;</p> <ul style="list-style-type: none"> • Updates to “Screening Documents” on page 4-1; • Updates to “Keying Requests” on page 4-2; • Updates to “CCMS Records” on page 4-3; • Updates to “RTS Forms - Return to State Process” on page 4-4; • Updates to “Family Planning Waiver Eligibility Span Rules” on page 4-4; • Updates to “RTS Forms - Return to State Process” on page 4-4; • Updates to “Family Planning Waiver Eligibility Span Rules” on page 4-4; • Deletion of “FP Waiver Batch Transmittal Form” from Section 4; • Replaced image for “Family Planning Waiver Input Form” on page 4-7; • Deletion of “Prepaid Mental Health Enrollment/Disenrollment” (formerly Section 5); • Deletion of “Filing Standards” from Section 5 (formerly Section 6); and • Updates to “Criteria for Filing” on page 5-1.
Version 13.2 Draft	June 12, 2017	Latoya Smith	<p>Updates per MFAO Letter #80835-17:</p> <ul style="list-style-type: none"> • Additions to “Receipt and Control of Requests” on page 2-1; • Revision of “Unborn Screening Process” on page 3-3; • Additions to “RTS Reasons” on page 3-5; and • Procedure item removal from “Keying the Request” on page 3-8. • Minor editorial updates, including global change of Fiscal Agent name from HPE to Gainwell.
Version 13.3 Draft	July 20, 2017	Latoya Smith	<p>Updates per MFAO Letter #81329-17:</p> <ul style="list-style-type: none"> • Update to “Receipt and Control of Requests” on page 2-1; • Update to “To Add a Parent Change Order:” on page 2-3; • Update to “5. For managed care segment updates (MCU), the

Document Version #	Modified Date	Modified By	Section, Page(s) and Text Revised
			<p>appropriate selection for the Grouping field is Gainwell Segment Updates.” on page 3-2;</p> <ul style="list-style-type: none"> • Update to “Unborn Screening Process” on page 3-3; • Corrections to SLA information throughout document; and • Global additions, as needed, to define the manual as specific to Operational File Maintenance.
Version 13.4 Draft	August 30, 2017	Latoya Smith	Update per internal MFAO review of v13.3: “Benefit Plan Panel” on page 4-2.
Version 14.0	September 7, 2017	Latoya Smith	Approved in MFAO Letter #81788-17.
Version 14.1 Draft	March 20, 2018	Latoya Smith	<p>Updated for 2018 and changed/added the following procedural steps:</p> <ul style="list-style-type: none"> • “Creating the Task Table Record” on page 2- 4; • “4. For managed care segment updates, the appropriate selection for the Subsystem field is Recipient Management.” on page 3-2; • “12. Clerk should enter a verification note from the template, “Unborn verified”, to indicate UB has been verified.” on page 3-9; and • “3. Clerk should enter verification note from template, “FP verified”, to indicate FP has been verified.” on page 4-4.
Version 15.0	April 12, 2018	Latoya Smith	Approved in MFAO Letter #83255-18.
Version 15.1 Draft	February 12, 2019	Latoya Smith	<p>Updated the following items:</p> <ul style="list-style-type: none"> • “Receipt and Control of Requests” on page 2- 1; • “Unborn Activation Process” on page 3-3; • “File Drawers 13-15: Unborns” on page 5-1; • “Glossary of Terms” on page G-1; and • Revised for grammar throughout. • Added image: • “Authorization” on page 4-6.
Version 15.2 Draft	June 10, 2019	Latoya Smith	Updated the following sections to remove information related to unborns and the Unborn Activation Process:

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			<ul style="list-style-type: none">• Removed list element from Section 1.3, “The Workload,” on page 1-1;• Removed Section 3.2, “Unborn Activation Process” on page 3-2; and• Removed part of Section 5.1, “File Drawers 13-15: Unborns” on page 5-1.
Version 16.0	June 13, 2019	Latoya Smith	Approved in MFAO Letter #85965-19.
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Version 17.0	June 23, 2020	Latoya Smith	Approved in MFAO Letter #87975-20.
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1 Introduction

1.1 Purpose

The primary purpose of the Operational File Maintenance Procedures Manual is to provide information necessary for the Operational File Maintenance (FM) staff to perform their job functions and identify the procedures that they use. This manual is intended to support the team by communicating key procedures and unit responsibilities. It is also a reference point for Medicaid Fiscal Agent Operations (MFAO) staff to assess procedures for handling operational responsibilities.

1.2 Overview

The Operational File Maintenance team is a part of the Program Services department overseen by the Claims Operations manager. The Operational File Maintenance team includes one (1) supervisor, one (1) team lead, and adequate staffing to perform the day-to-day operations of the unit.

The Operational File Maintenance team is responsible for adding, updating, and deleting various computer tables and records. Operational File Maintenance clerks perform file maintenance to the Reference and Recipient functional areas, as well as enter requests for history profiles.

1.3 The Workload

To the greatest extent possible, requests will be worked on a first-in/first-out basis.

1. Managed Care Segment Updates-Duplicate Requests;
2. Procedure code additions (text and pricing only), and alteration of procedure, drug, and diagnosis files (Health Care Procedure Codes (HCPC); International Classification of Diseases, Tenth Edition (ICD-10) codes; revenue center codes; and diagnosis codes);
3. Text and resolution instructions (resolution instructions, explanation of benefits (EOB) code text, location code text, procedure code text); and
4. Family planning (FP) waivers.

Clerks must prioritize their work to ensure that MFAO and Gainwell Technologies imposed deadlines are met or exceeded. If at any time a clerk realizes that assistance is needed in meeting a deadline, the clerk must contact the Claims manager or Operational File Maintenance leadership so workloads can be arranged to accommodate the deadline. All requests are counted and logged in the File Maintenance Inventory Daily Spreadsheet.

Service Level Agreement (SLA)
I. Provide sufficient data entry staff to key in eligibility data from documents submitted by the State within three (3) workdays of receipt. 40.2.2.6.4 sub b
II. Return to the State (RTS) within two (2) workdays of determining any input documents that cannot be keyed under procedures approved by the State. 40.2.2.6.4 sub c

Service Level Agreement Requirements

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2 The Reference Functional Area

The Reference functional area is a collection of computer tables and records that store information used by the Claims Processing functional area, as well as most other Florida Medicaid Management Information System (FMMIS) functional areas. The Reference functional area contains information on procedures, drugs, diagnosis, exception codes, special pricing, utilization review, and resolution instructions. The Reference files, tables, and records are maintained online, and the information is immediately available for update or inquiry.

2.1 Receipt and Control of Requests

MFAO delivers all requests for Reference File Maintenance (Table Updates), Rules Engine Updates, Application configurations, Edit/Audit modifications, and Managed Care Segment Updates-Duplicate Files to the FLMMISFileMaintenanceTeam@dx.com email drop box. Any paper forms received should be returned to MFAO.

All requests are reviewed to determine whether they can be worked by the Operational File Maintenance Department or should be forwarded to the Systems Business Analyst (BA) team for processing. Listed below are the file maintenance requests handled by the Operations team for completion.

1. Operations FM Request;
2. Procedure Codes (Max Fee Updates);
3. Error Disposition Panel; and
4. Managed Care Segment Updates.

The Operational File Maintenance Department creates the Parent and Child Change Orders (COs), and replies to the original email with the action taken (key, RTS, or forwarded to BA) when COs are created. Listed below are the FM requests that are forwarded to the Systems team for completion.

1. FM requests forwarded to Systems Business Analysts:
2. Hospice Rates Updates;
3. Transplant Rates Updates;
4. Kick Payment Updates;
5. Presumptive Eligible Hospital Updates;
6. Medical School Updates;
7. Processing of “UR” Urgent File Maintenance;
8. HCPCs Processes, including Medicare CO-Insurance Rate Updates;
9. Medical Assistance Provider Incentive Repository (MAPIR) Updates; and
10. Reason Code Updates/Additions:
 - a. Accounts Receivable (A/R); and
 - b. Call Center Management System (CCMS).

Prior to entering the request in the Florida Interactive Portal (FIP), an authorized requester reviews each request for an MCM tracking number and signature. The type of request, date received, and date due are all entered into the corresponding FIP task. Each file maintenance

request is logged in the Operational File Maintenance Daily Spreadsheet, then saved to a date- stamped folder after completion.

2.2 Procedure and Diagnosis Tables

The Procedure, Drug, and Diagnosis tables contain records for each procedure, drug, and diagnosis code used by the Claims Processing functional area.

Procedure Records

The procedure code records include HCPCs; International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) codes; ICD-10 codes; and revenue codes. HCPCs are used on CMS-1500 claim forms. ICD-10 codes and revenue codes are used on UB-04 claim forms. These codes indicate the services or procedures performed.

1. Scan the document for completion. Make sure that all fields on the form are completed and all dates are in mm/dd/yyyy format.
2. Look at the document (request) and key all the required and appropriate optional fields. Requested updates to the record may be circled or written in red. Check the entire document for any changes to the fields. Remember: If the short name is too long, key as much of the request as possible.
3. There may be a request to update the fees. These are completed on the Max Fee panel.
4. Procedure, Drug, Revenue, and Diagnosis requests must be processed within three (3) workdays of the date stamp (not including the day of the stamp), or forwarded to the correct system business analyst for processing. They MUST be verified. This ensures that claims following the update will be processed correctly.
5. Any additions, updates, or deletions of the information on the tables or records are captured on the Audit History panel and available for viewing immediately after an update is made.

Diagnosis Records

Most Medicaid providers are required to use diagnosis codes on their claims. A diagnosis code indicates the type of illness and justifies why the service was performed. Refer to the FMMIS Claims Processing Administration Participant Guide to add or update a diagnosis code record.

All requests to add or update a diagnosis code record are forwarded to the appropriate system business analysts, project managers, and State participants through FIP by the Operational File Maintenance Team. Each FIP Record created must have a Parent with a Child CO attached.

Creating a FIP Record for Reference Updates

All procedure, revenue, diagnosis, and reference codes must have a record in FIP for tracking purposes. Each FIP record created must have a parent FIP with a child FIP record attached.

Once on the FIP main page, the keyer proceeds to enter a task.

To Add a Parent Change Order:

1. The keyer clicks the “ADD” button.

2. In the “Short Name” field, the keyer enters the naming convention “FM,” FM Short Name from the form. Remember: If the short name is too long, key as much of the request as possible.
3. For example, a procedure code update received on January 1, 2016, would be keyed as “FM” 16001 Procedure Code Update.
4. The Project name defaults to FL MMIS/DSS Operations.
5. The keyer selects his or her manager or supervisor name from the Owner drop-down field.
6. The keyer selects the Change Order Type-CO File Maintenance from the drop-down field.
7. For procedure, revenue, diagnosis, and reference codes, the appropriate selection for the Subsystem field is Reference.
8. For requests completed by the Operational File Maintenance team, the appropriate selection for the Grouping field is Gainwell File Maintenance. For requests that need to be forwarded to System File Maintenance, the Grouping field is MFAO OM FM.
9. All documents received by email retain a Priority level of 2-Medium, unless otherwise specified in the email.
10. The keyer enters the MFAO tracking number from the form in the MCM Tracking ID field.
11. In the Desired Narrative field, the keyer notes the request from the File Maintenance Attachment Sheet.
12. The keyer then clicks the ADD CO button to create the task.
13. On the Document Upload subordinate panel, the keyer uploads the document of the request and attaches it to the FIP task.
14. The keyer adds the appropriate status to the FIP task; for example, “task completed.”
15. On the Participant subordinate panel, the keyer adds the appropriate participant necessary to complete the request.
16. The due date is three (3) workdays from the receipt of the document, not including the date of receipt.

To Add a Child CO:

1. The keyer clicks the “ADD” button.
2. In the “Short Name” field, the keyer enters the naming convention “FM”, Tracking CO#, followed by the FM Short Name from the Parent CO. For example, a procedure code update received on January 1, 2016 would be keyed as “FM” CO# 94521 16001 Procedure Code Update.
3. The Project name is defaulted to FL MMIS/DSS Operations.
4. The keyer selects his or her name from the Owner drop-down field.
5. The keyer selects the Change Order Type-Task from the drop-down field.
6. For procedure, revenue, diagnosis, and reference codes, the appropriate selection for the Subsystem field is Reference.
7. For procedure, revenue, diagnosis, and reference codes, the appropriate selection for the Grouping field is Gainwell File Maintenance.

8. All documents received by email retain a Priority level of 2-Medium, unless otherwise specified.
9. The keyer enters the MFAO Tracking Number from the form in the MCM Tracking ID field.
10. In the Desired Narrative field, the keyer notes the received date, the received amount, the return to State amount, the forward to business analyst amount, and the date completed.
11. The keyer clicks the ADD CO button to create the task.
12. For the CO ID field, the keyer clicks the Predecessors button, enters the Parent CO ID in the CO ID field, then clicks find. Once the CO ID populates, the keyer will click the Add As Predecessor button.
13. The keyer adds the appropriate status to the FIP task; for example, “task completed.”
14. The due date is three (3) workdays from the receipt of the document, not including the date of receipt.

Creating the Task Table Record

1. Copy Short Name from Parent CO;
2. Change Order Type - Task Table Data;
3. Subsystem - Reference;
4. Grouping - MFAO OM FM;
5. Status - Ready for Prod Impl (approval from MFAO);
6. Doc Upload - Screen shots of before and after production; and
7. Release tab:
 - a. Environment - Production; and
 - b. Release Date.

Deleting Records from Any File

Clerks must not delete records from the Procedure, Drug, or Diagnosis tables for any reason. If a request for deletion is received, notify the file maintenance supervisor or program services manager, so the requester can be contacted regarding the request.

2.3 Error Disposition Tables

The Error Disposition tables control edits that post to a claim, specify the criteria that must be met for the edit to post, and maintain text used to communicate with Medicaid providers and recipients or provide instructions to Gainwell staff. Access to the Text and Exception Control tables is through FMMIS.

General Instructions and Features for all Text Records

1. When adding text, some fields may already contain information. This information is added to the record unless it is changed or erased. This helps the keyer differentiate between a request for a text addition versus a simple alteration.
2. In the resolution instruction records of the EOB and exception text files, the four (4) digit code cannot be changed; only the text portion of the record can be updated. All other disposition changes are altered by the responsible business analyst.

Error Disposition Record

The text record contains narrative or text used by FMMIS for various purposes. Some text records are accessed by the Claims Processing functional area and used as a way to communicate information to providers via the remittance advice. Other text provides instructions to claims clerks when they are resolving suspended claims.

The Operational File Maintenance team updates the following text records:

1. Resolution Instructions: instructs resolution clerks resolving suspended claims how to work edits that post to a claim.
2. Explanation of Benefits Description: appears on providers' remittance advices and explains the status of claims submitted.
3. Location Description: describes the location codes used to direct suspended claims into queues (or locations) for resolution.

Add or Update a Text Record

To add or update a text file record, refer to the FMMIS Claims Processing Administration Participant Guide.

1. Look at the document (request) and key all required and appropriate optional fields onto the panel. Requested updates to the record are usually circled in red. Check the entire document for any changes to the fields.

The system does not allow input of invalid data.

Example: If an alphabetic character is entered into a field that is only valid for numbers, the system produces an error message, and the user is required to correct any errors before saving or proceeding with the update.

2. When there are no errors and the update is complete, click "save" to update the record.
3. Send a copy of all text exceptions to the Resolutions supervisor via interoffice courier.

Resolution Instructions

The resolution instructions provide direction to resolution clerks resolving suspended claims. Each resolution instruction record can contain up to 99,999 lines. Each line may contain up to 72 characters. To update the exception text, refer to the FMMIS Claims Processing Administration Participant Guide.

EOB Code Text

The EOB code text file record describes the four (4) digit code that appears on the provider's remittance advice. To update the EOB code text record, refer to the FMMIS Claims Processing Administration Participant Guide.

Related Data

The location description file describes the two (2) digit code assigned to each exception code. The system directs suspended claims into queues (locations) for resolution. To update the location description text file, refer to the FMMIS Claims Processing Administration Participant Guide.

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3 Recipient Eligibility

A variety of data entry input forms are used to update the Recipient functional area. The following sections give instructions for their entry.

3.1 Managed Care Segment Updates-Duplicate Request

Managed Care segment updates are requested by MFAO for Gainwell to update the Primary Medical Provider (PMP) assignments panel for selected recipients. These requests are submitted via email.

After all documents have been logged and counted, they are forwarded to the responsible keyer. The responsible keyer enters the recipient's ID to begin making the requested changes.

1. The keyer clicks the Managed Care link in the Recipient Maintenance navigation panel.
2. Once on this panel, the keyer clicks the PMP Assignments.
3. Once the PMP panel displays, the keyer scans the request for complete dates in mm/dd/yyyy format and for the current spans on file to match the spans on the request.
4. Once the scanning process is complete, the keyer begins to key, adjust, or history the request.
5. Once the Managed Care Segment Updates-Duplicate Files request has been keyed, adjusted, or historied, the keyer adds the appropriate notation in the Recipient Comments panel, located in the Recipient Maintenance navigation panel.

Action	Notation
History a segment (Duplicate File)	History a segment - Begin date end date status and plan ID.
Add a segment (Primary File)	Add a segment - Begin date end date status and plan ID.
Adjust (change) (Primary File)	Adjust a segment - Begin date end date status and plan ID.
Managed Care Already Active (Primary File)	Managed Care Request AA - Begin date end date status and plan ID.
No actions needed.	Assignment plan for primary prior to assignment plan begin date for duplicate file.
No actions needed.	Plan chosen for primary was voluntary.

Creating a FIP Record

All Managed Care Segment Updates-Duplicate Files must have a record in the Florida Interactive Portal (FIP) for tracking purposes.

Once on the FIP main page, the keyer proceeds to enter an FIP task.

1. In the Short Name field, the keyer enters the naming convention "FM", the two (2) digit year, the three (3) digit Julian date for the date received, and the request type. For example, a Managed Care Segment Update-Duplicate File received on January 1, 2016 would be keyed as "FM" 16001 Managed Care Segment Update (MC).
2. The Project name is defaulted to FL MMIS/DSS Operations.
3. The keyer selects his or her name from the Owner drop-down field.

4. For managed care segment updates, the appropriate selection for the Subsystem field is Recipient Management.
5. For managed care segment updates (MCU), the appropriate selection for the Grouping field is Gainwell Segment Updates.
6. All documents received by email retain a Priority level of 2-Medium, except for emailed Managed Care segments and Recipient review updates which render a priority of 0-Emergency.
7. The keyer enters MCM Tracking ID field, which is formatted as “MCU” followed by the two (2) digit month, day, and year.
8. In the Desired Narrative field, the keyer notes the primary and duplicate recipient IDs being worked, the received date, the received amount, the return to State amount, the forward to business analyst amount, and the date completed.
9. The keyer clicks the ADD CO button to create the FIP task.
10. On the Document Upload subordinate panel, the keyer scans the image of the request and attaches the image to the FIP task.
11. The keyer adds the appropriate status to the FIP task; for example, “task completed.”

The due date is five (5) workdays from the receipt of the document, not including the date of receipt, unless otherwise specified.

All Managed Care Segment Updates to FIP Records should be closed after completion.

4 Family Planning Waiver Program

The Family Planning Waiver Program was developed to reduce unplanned pregnancies and to help women receive family planning services. With the waiver program, women who have lost Medicaid coverage for any reason are provided limited family planning services for up to 24 months. Under this program, women are provided annual physical exams, including a pap smear, birth control supplies, pregnancy testing if indicated, limited treatment for sexually transmitted infections, and related medicines and lab tests.

4.1 Receiving FP Documents

1. Date-stamp all FP Waiver forms.
 - a. DO NOT date-stamp additional documents attached to the forms.
 - b. DO NOT date-stamp the family planning applications. These are sent to the County Health Department (CHD).

4.2 Screening Documents

1. Assigned clerk checks each document for complete information.
2. Check for date stamps on all forms.
3. All fields on documents must be filled out, including:
 - a. Date of Birth as MM/DD/YYYY;
 - b. Authorization section (Return address is not required for processing); and
 - c. Name (if first or last name is slightly misspelled, continue screening process), address, DOB, and SSN.
 - d. Middle initial is NOT required.
4. RTS if date spans are not in mm/dd/yyyy format. Example: 12/01/2012 – 09/30/2013.
5. RTS if date spans are not in chronological order. Example form reads:
12/01/2015 – 09/30/2016
12/01/2016 – 09/30/2017
6. Date spans must start with the first day of a month and end with the last day of a month. If either or both are incorrect, the form must be RTS.
7. Coverage can be added for 1 month for recipient, even if it is not based off last Full Medicaid end date.
8. Documents that are missing fields are sent to the Department of Health (DOH).
9. Documents with illegible information are sent to DOH.

4.3 Keying Requests

The following sections outline the procedures for entering recipient requests.

Recipient Panel

1. Once the documents have been received, date-stamped, and screened, they are forwarded to the clerk assigned to key them.
2. Send any document that has a different recipient in FMMIS than the one listed on the form to DOH.

3. Differences in the SSN, date of birth, and/or Recipient ID are returned to DOH.
4. Any request that cannot be keyed due to duplicate records, error messages received by the FMMIS, “recipient not on file,” “demographic information not correct” (except address), “invalid eligibility spans,” or “requested change already on file,” is sent to DOH.
5. If the address on the form does not match FMMIS, the clerk is required to update the address on file to match the form sent from the CHD.
6. If the Zip Code and the + 4-digit extension does not update after changes have been made, clerks are to leave a brief comment stating that changes cannot be made in the Recipient Comment panel and the CCMS Record.

Benefit Plan Panel

1. Check the date that full Medicaid coverage ended. This determines the valid date span for family planning coverage.
2. The date span must begin with the first day of a month and end with the last day of a month. If either or both are incorrect, the form must be RTS.
3. The request can be for no longer than twelve (12) months of coverage. If the CHD gives the recipient two (2) years of coverage, it must be requested in two (2) separate date span requests. No more than two (2) years of coverage can be given at a time.
4. Coverage can be retroactively activated even if it is in a previous year, as long as all requirements are met.
5. To determine if the date span request is a valid request, please see the following example:

In the Benefit Plan panel, the full Medicaid coverage ended on May 31, 2015.

Note: There is a specific time the second year of coverage can be given.

If the form is signed on June 24, 2016, and the first year of coverage ends August 31, 2016, it is too early to put November 1, 2017, on file for the second year because the application sign date exceeds sixty (60) days.

Note: If the form has documents attached, key the form (if possible). Attach each document to the Input form.

If you cannot key the form, enter RTS reasons in the Recipient Comment panel as well as the CCMS Record.

If a Waiver Family Planning (WFP) span is requested that overlaps with Title XIX or SSI coverage, add the WFP for the appropriate months and return the input form. The RTS letter should be attached with an explanation of the action taken. Enter a comment in the Recipient panel: WFP cannot overlap with Medicaid and the partial span dates that were added.

Example: FP span on input form is May 1, 2017 to December 31, 2017, but Title XIX is open from January 1, 2017 to June 30, 2017. Add FP span from July 1, 2017 to December 31, 2017, and return to DOH with an explanation.

6. If the system automatically adds family planning (when MM P closes), recipient comment should state “coverage already active.” Return input form with RTS letter attached to DOH.

4.4 CCMS Records

All FPs require a CCMS record. These are used for tracking purposes and are noted on all FPs.

Add a CCMS record as stated:

1. Click “CCMS Information”, located under the CCMS functional area.
2. FMMIS automatically enters the fields associated with the keyer’s information.
3. The keyer then clicks the Base Information and Questions panels. (The Notes panel opens as a subordinate of the Questions Panel.)
4. The Contact Method “L-Inbound Written Correspondence/Letter” is chosen.
5. The Contact Source “R-Recipient” is chosen.
6. The “In House date” (the date the FP was received by the FM team) is added.
7. The “Priority” status is always set to 3-Medium.
8. The “Status” is always set to pending (P) when the clerk creates a ticket. If an FP document is returned to DOH, use S for Return to State. The status will be set to closed once the document has been verified.
9. The “Reason code” is always “Other”.
10. The “Document ID” is the number located at the bottom right of the FP.
11. When the FP is new, the “Description” is “Family Planning Span Date Added.”
12. When the FP is keyed, verified, and closed, click “save”, and write the Contact Tracking Number (CTN) on the FP.

4.5 RTS Forms - Return to State Process

1. For those forms that were RTS, indicate “RTS” and the reason (authorization box not complete, incorrect date span, invalid end date, date spans not listed in chronological order, form not complete, missing fields, and so forth).
2. Give all assigned FPs to the assigned verifier. Once the FPs are verified, the verifier will make a note in the recipient comments if the document was verified with their user ID. If any errors are found, the verifier will return the documents to the keyer to make the necessary corrections.
3. Clerk should enter verification note from template, “FP verified”, to indicate FP has been verified.

4.6 Family Planning Waiver Eligibility Span Rules

Fundamental Rules

Fundamental Rule 1:

The eligibility span end date for the first year of FP eligibility may not exceed one (1) year from loss of full Medicaid coverage.

Example: Ms. One lost full Medicaid coverage June 30, 2015. Her FP eligibility end date for the first year of coverage is June 30, 2016.

Fundamental Rule 2:

The eligibility span end date for the second year of FP eligibility may not exceed two (2) years from loss of full Medicaid coverage.

Example: Ms. Two lost full Medicaid coverage July 31, 2015. Her FP eligibility end date for the second year of coverage is July 31, 2017.

Fundamental Rule 3: (Effective April 19, 2005)

Any woman who loses full Medicaid coverage is eligible the first day of the month she applies for the program with the health department. The month she applies is based on the date the application is signed. If she delays in applying at the health department, no retroactive coverage is allowed. The FP eligibility span end date is still only one (1) year from loss of full coverage if she applies in the second year.

Example: Ms. Three lost full Medicaid coverage December 31, 2014. She applies for the program March 15, 2016. She lost her first year of coverage. Her second-year eligibility span would be March 1, 2016 to December 31, 2016.

Clarifying Rules

1. If an applicant is deemed eligible and MM P shows in FMMIS prior to Gainwell entering FP eligibility spans in FMMIS, the woman is not eligible for the FP waiver.

Example: Ms. Doe lost full Medicaid coverage June 30, 2015, and applied for Family Planning Waiver services August 15th. She was approved for the first year of FP coverage August 1, 2015 to June 30, 2016. Prior to the FP eligibility span being added to FMMIS, Ms. Doe was approved for MM P coverage effective September 1, 2015. She is no longer considered eligible for the FP waiver and should not have any FP coverage added to her record.

2. Effective April 19, 2005, if the Waiver Input document is completed (that is, signed and dated by a DOH supervisor) in a different month from the date the application is signed, under the eligibility span dates, the CHD must note the date the application was signed. The requested date span cannot begin prior to the date the application was signed. If the application was signed July 13, 2015, the span must begin on or after July 1, 2015.

Example: Family planning waiver eligibility span: March 1, 2015 to February 28, 2016, FP Category.

Begin (mm/dd/yyyy) End (mm/dd/yyyy)

Application signed March 20, 2015.

Authorization

Authorization	
Before requesting this coverage be added to the file, the person completing this form checked FMMIS by <input type="checkbox"/> Recip ID <input type="checkbox"/> SSN	
_____ Print name of DOH eligibility staff	_____ Date
_____ Signature of DOH Supervisor	(____) ____-____-____ Area Code Phone Number
_____ Print name of DOH Supervisor	
Fiscal Agent Use Only	
_____ Name of person entering data on FMMIS	Date Entered: ____/____/____ M M D D C C Y Y
DH 3218, 4/15	

Authorization Form

General Comments:

If the print name is in cursive, continue processing the form.

The codes below are full-service Medicaid eligibility codes FMMIS uses to identify female recipients who may be eligible for the family planning waiver. Use these codes to identify when a recipient loses full Medicaid coverage in determining eligibility spans.

Medicaid Full Coverage Eligibility Codes					
MA I	ME I	MO D	MP U	MRR	MT D
MA R	ME T	MO P	MREI	MRTA	MT S
MA U	MH A	MO S	MRMC	MRTC	MT W
MB C	MM C	MO T	MRMP	MRTD	MW A
MCAE	MM P	MO U	MRMS	MRTW	MX
MCAN	MM S	MO Y	MRMT	MS	
MCFN	MM T	MP C	MROT	MT A	
ME C	MO A	MP N	MRPN	MT C	



Medicaid Family Planning Waiver Input Document

This form is to be used by Qualified Designated Personnel who determine family planning waiver eligibility only. All of the information **must** be completed to add coverage. **Please print clearly.** Mail this form to the Medicaid fiscal agent at HP Enterprise Services, P.O. Box 7060, Tallahassee, FL 32314-7060.

Recipient Medicaid ID: _____ SSN: X X X X - _____
(must match FMMIS) (Last 4 digits only. Must match FMMIS*)

Recipient Name: _____
(must match FMMIS) Last First MI

Address: _____
Number Street Apt. #

City/Town FL State Zip

Date of Birth: / /
(must match FMMIS)

*If SSN does not match FMMIS, contact AHCA, Recipient File Management Unit, 850-922-4497

Family Planning Waiver Eligibility Span: / / to / / FP
Begin (mmddccyy) End (mmddccyy) Category

Date Application Signed: / /
MM DD CC YY

Authorization

Before requesting this coverage be added to the file, the person completing this form checked
FMMIS by ☐ Recip ID ☐ SSN

Print name of DOH eligibility staff _____ Date _____

Signature of DOH Supervisor _____
(_____) _____
Area Code Phone Number

Print name of DOH Supervisor _____

Fiscal Agent Use Only

Name of person entering data on FMMIS Date Entered: / /
MM DD CC YY

DH 3218, 4/15

Family Planning Waiver Input Form

5 Filing

The following sections describe the process followed for filing requests received by Gainwell.

5.1 Criteria for Filing

Before filing, check all documents for date stamps, signature, date of keyer, and signature and date of verifier. Verify that the log sheet has been completed correctly. Documents not completed correctly are not filed, but they are returned to the supervisor. All documents are to be neatly stapled, binder clipped, or rubber-banded together. Do not use paper clips.

File Drawers 16-18: FPs

FP - File by date of receipt in a manila folder. Label each folder a separate month in MMDDYY - MMDDYY format.

Note: Before archiving any information from filing drawers, see your immediate supervisor to verify retention dates.

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Appendix A Glossary of Terms

The following table provides a glossary of terms taken from the Florida Request for Proposal (RFP) with the addition of Gainwell Technologies terminology that may be used in project communications. In the Term column, the phrase or acronym is given with its preferred capitalization. In the Definition column, acronyms are spelled out (with correct capitalization) and definitions are given.

Acronyms are always spelled out on first use in a document; for example, Income Eligibility Verification System (IEVS).

Term	Definition
.NET	(pronounced dot-net) - An initiative by Microsoft to create a new software development platform focused on network transparency, platform independence, and rapid application development.
3DES	(Triple Data Encryption Standard) A mode of the DES encryption algorithm that encrypts data three times. Three 64-bit keys are used instead of one.
A	
AAAD	Avaya Aura Agent Desktop (called triple-AD) Phone software used in Gainwell Technologies call centers
ABA	American Bankers' Association
ACA	Affordable Care Act
access	Refers to the ability or the means necessary to read, write, modify, or communicate data/information or otherwise make use of any system resource.
accretion	The process by which the State begins to pay the Medicare premiums.
ACWM	Assistance Categories with Modifiers
ad hoc request	A request to provide non-production reports.
adjudicate	To determine whether all program requirements have been met and whether the claim can be paid, denied, suspended, or if the encounter data would be paid or denied.
adjudicated claim	A claim that has reached final disposition such that it can either be paid, or denied, or determined if it would be paid or denied.
adjustment	A transaction that changes any payment information on a previously paid claim.
Agency	The Florida Agency for Health Care Administration
AHCA	Agency for Health Care Administration
AHS	Automated Health Systems
aid category	An alpha and numeric code identifying the criteria used to determine an individual's eligibility. Aid Categories are the equivalent to Florida Program Codes or Assistance Categories with Modifiers (ACWM).
AIMM	Asset Impact Management Module
APC	American Power Conservation
APD	Advanced Planning Document Also, Agency for Persons with Disabilities.
ARNP	Advanced Registered Nurse Practitioner
ASA	Average Speed of Answer
ASC	Ambulatory Surgical Center

	An ASC is a distinct entity that operates exclusively to provide surgical services to patients not requiring hospitalization and has an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare as an ASC. ASCs must be state-licensed and Medicare certified. An ASC may be either independent (that is, not a part of any other facility) or hospital-affiliated.
ASN	Alternative Service Network A network of providers under separate contract to provide services to a list of Medicaid recipients and share in cost-savings for efficient patterns of care.
Assignment plan	An assignment plan identifies specific prepaid services covered under a recipient's enrollment. Refer to Medicaid Programs.
Assistance Category with Modifiers (ACWM)	See Aid Categories.
AUX	Auxiliary
ATN	Application Tracking Number
AVRS	Computerized Automated Voice Response System Used to supply recipient eligibility information or claims status to providers via telephone.
B	
backbone	Cat5 and Gigabit Cabling, Multi-mode Fiber Optics or combination of both Ethernet and Gigabit switches.
BAM	Business Activity Monitoring
BDD	Business Design Document, includes Use Cases for the given business area.
BENDATA	State Beneficiary Data File – used to submit input records to Social Security Administration (SSA) in order to establish or discontinue BENDEX exchange, or to modify AHCA controlled data fields.
BENDEX	Beneficiary Data Exchange System A file containing data from the federal government regarding all persons receiving benefits from the SSA.
beneficiary	A person receiving Medicare.
Benefit plan	A benefit plan is a group of covered services a recipient is eligible to receive. AKA Medicaid Programs.
BESST	Beneficiary Enrollment Software and Systems Technology It is the incumbent fiscal agent choice counseling system where Medicaid recipients' managed care choices are recorded.
bidder	A vendor who returns a properly completed bid in response to a request for solicitation from an authorized state or agency-purchasing agent.
BIC	Beneficiary Identifier Code
BPEL	Business Process Execution Language
BPS	Business Process Services (formerly BPO Business Process Outsourcing)
BSCI	Brain and Spinal Cord Injury
Business Associate	A business associate is a person or entity who performs or assists on behalf of the Agency.

	Performs or assists in the performance of: a function or activity involving the use or disclosure of protected information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or any other function or activity regulated by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule; or Provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the Agency, where the provision of the service involves the disclosure of protected information from the Agency or from another Agency business associate. A covered entity may be a business associate of another covered entity. Agency workforce members are not considered to be Agency business associates.
buyer	An entity that has released the solicitation.
Buy-In	A procedure whereby the state pays a monthly premium to the Social Security Administration on behalf of eligible Medicaid recipients, enrolling them in the Medicare Title XVIII Part A and Part B Program.
C	
calendar day	A twenty-four-hour period between midnight and midnight, regardless of whether or not it occurs on a weekend or holiday.
calendar year	A twelve-month period of time beginning on January 1 and ending on December 31.
can	Used to express non-mandatory provisions; words denote the permissive.
caps	Limits on services available to a Medicaid recipient, such as the number of dentures a recipient may receive.
carrier	An organization processing Medicare Part B claims on behalf of the federal government.
CBT	Computer Based Training Formal course materials delivered through an interactive web-based training application.
CCB	Change Control Board
CCMS	Call Center Management System
CDT	Current Dental Terminology
CECE	Centre for Enabling Client Excellence
Certification	The written acknowledgment by the Centers for Medicare and Medicaid Services (CMS) that the operational MMIS meets all legal and operational requirements necessary for 75% Federal Financial Participation (FFP).
CFR	Code of Federal Regulations The federal rules that direct the state in its administration of the Medicaid program and implementation and operation of an MMIS.
CHAMPUS	Civilian Health and Medical Program Uniformed Service - The US Government program that provided insurance to military dependents and retirees, now replaced by TRICARE.
CHCUP	Child Health Check-Up Formerly (EPSDT) Early, Periodic, Screening, Diagnosis and Treatment.
CHD	Florida County Health Departments
CHIP	Children's Health Insurance Program
CHOW	Change of Ownership

CI	Configuration item
CIA	Certified Internal Auditor
claim	A request for Medicaid to pay for health care services.
“Clean Desk” Practice	A practice that ensures no Protected Health Information (PHI) is exposed to those who don’t have a “need to know” the information. This policy includes not leaving PHI information exposed on your desk, locking your computer when you leave your desk so no one else can see PHI on your display, and having your monitor placed on your desk so that no one can walk up behind you and see information on the screen.
CLIA	Clinical Laboratory Improvement Amendments Provisions of 1988 which requires all laboratory testing sites to obtain either a certificate of waiver or a certificate of registration along with an identification number in order to legally perform testing anywhere in the United States.
CM	Configuration Management
CMAT	Children’s Multidisciplinary Assessment Team
CMM	Capability Maturity Model An Information Technology (IT) system development methodology developed and promoted by Carnegie Mellon University to measure and certify the methods and controls used by a company or agency in the development of IT systems.
CMMI	Capability Maturity Model Integration
CMS	Centers for Medicare and Medicaid Services The organizational unit of the U.S. Department of Health and Human services responsible for administration of the Title XIX Program under the Social Security Act. CMS was formerly called the Health Care Financing Administration (HCFA). In Florida, CMS may also refer to Children's Medical Services within the Florida Department of Health.
CMS	Children’s Medical Services Network
CNHDP	Community Nursing Home Diversion Pilot (more commonly known today as the Nursing Home Diversion Waiver)
CO	Change Order
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor
COLD	Computer Output to Laser Disk
compliance date	The date by which the Agency and other covered entities must comply with a standard, implementation specification, requirement, or modification adopted under the HIPAA rules. The compliance date for the HIPAA privacy rule is April 14, 2003.
compound drug	A medication that is a combination of two or more pharmaceuticals.
contingency plan	The action(s) to be taken if a previously identified risk event should occur.
contract	The written, signed agreement resulting from and inclusion of this RFP; any subsequent amendments thereto and the proposer’s proposal.
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract; it shall include bilateral actions, such as administrative changes, notices of termination, and notices of the exercise of a contract option.

contract manager	The Agency's individual responsible for providing overall project direction as liaison between contractor and Medicaid staff, and monitors contractor performance.
contractor	The successful proposer (fiscal agent) with which the state has executed a contract that processes and adjudicates provider claims on behalf of the state.
COOP	Continuity of Operations Plan A plan that incorporates disaster recovery, risk analysis, and contingency planning to assure continued operation of fiscal agent responsibilities in case of a disaster, system failure, work stoppage, or other occurrence.
copay	Copay is the fee paid by the recipient to the provider at the time the service is rendered, unless the recipient is exempt from that liability.
correctional institution	Any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, Florida, a territory, a political subdivision of Florida for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody include juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.
cost-based reimbursement	Reimbursement based on the provider's actual costs for rendering services to Medicaid recipients. Some providers who are reimbursed on a cost basis are: county health department clinics, federally qualified health centers, and rural health clinics.
COTS	Commercial-Off-The-Shelf software application
covered entity	Defined as: <ul style="list-style-type: none"> • A health plan; • A health care clearinghouse; or • A health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA. The HIPAA regulations specifically designate Medicare, Medicaid, and the Children's Health Insurance Program as covered entities that must comply with HIPAA.
covered functions	Those functions that a covered entity performs that make it a health plan, health care provider, or health care clearinghouse.
covered service	Mandatory medical services required by CMS and optional medical services approved by the state for which enrolled providers will be reimbursed for services provided to eligible Medicaid recipients.
CPA	Certified Public Accountant
CPT	Current Procedure Terminology Unique coding structure scheme for all medical procedures approved by the American Medical Association - Fourth Edition.
crossover claim	A claim submitted by a Medicare/Medicaid provider to a Medicare carrier or intermediary on behalf of a dual Medicare/Medicaid eligible or Qualified Medicare Beneficiary that has been paid by Medicare and crossed over to Medicaid for payment of the Medicare deductible and/or coinsurance.
CSR	Customer Service Request An official notification to the fiscal agent to initiate a modification or additional requirement in FMMIS.

CTI	Computer Telephone Integration
CTN	Contact Tracking Number
D	
data aggregation	Protected information created or received by a business associate in its capacity as an Agency business associate that the business associate combines with protected information it receives in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the Agency and the other covered entities.
day	Calendar day, unless specified as a workday.
DB (or db)	Database
DBA	Database Administrator Also, Doing Business As, which is used in Provider Enrollment.
DDE	Direct Data Entry
DCF	Department of Children and Families DCF is the Florida agency that determines Medicaid eligibility in many categories and operates the Florida Online Recipient Integrated Data Access (FLORIDA) system to record Medicaid eligibility and eligibility for other state assistance programs.
DEA	Drug Enforcement Agency
deletion	The process by which the state stops paying the Medicare premiums.
deliverable	All software, documentation, reports, manuals, and any other item that the Vendor is required to produce and/or tender to the state under terms and conditions of this contract.
denied claim	A claim for which no payment is made to the provider because the claim is for non-covered services, is for an ineligible provider or recipient, is a duplicate of another similar or identical transaction, or does not otherwise meet State standards for payment.
designated record set	A group of records maintained by or for the Agency that is: <ul style="list-style-type: none"> • The medical records and billing records about individuals maintained by or for a health care provider; • The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Agency; or • Records used, in whole or in part, by or for the Agency to make decisions about individuals. The term record refers to any item, collection, or grouping of information that includes protected information and is maintained, collected, used, or disseminated by or for the Agency.
DFS	Department of Financial Services (State of Florida)
diagnosis	The classification of a disease or condition.
DIP	Detailed Implementation Plan A document that clearly and specifically defines each task and subtask and specifies a completion date.
Disaster Recovery and Back-up Plan	A plan to ensure continued claims processing through adequate alternative facilities, equipment, back-up files, documentation and procedures in the event that the primary processing site is lost to the contractor.
disclosure	The release, transfer, provision of access to, or divulging in any other manner of information outside of the Agency.
DME	Durable Medical Equipment

DMO	Disease Management Organizations
DOAH	Department of Administrative Hearings (State of Florida)
DOC1	Group1 letter template generator application
DOEA	Department of Elder Affairs (State of Florida)
DRG	Diagnosis Related Group
Drug Rebate	Program authorized by the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) in which legend drug manufacturers or labelers enter into an agreement with the Secretary of the Department of Health and Human Services (DHHS) to provide financial rebates to states based on dollar amount of their drugs reimbursed by the Medicaid program.
DSS	Decision Support System Component of a data warehouse that provides analytical-level queries and reporting.
DSSU	Disk Staging Storage Unit
DUR	Drug Utilization Review Drug Utilization review is a process whereby the pharmacist reviews the prescription and the patient record for therapeutic appropriateness.
E	
E2	Group1 Retrieval of past letters (application)
EAGLE	Estate and Casualty Accounting Reporting System An application used by Third Party Liability to track activity in recovering Medicaid funds from Medicare, casualty cases, commercial carriers, and estate.
EBP	Enrollment benefit plan
ECS	Electronic Claims Submission Electronic methods of claims submission.
ED	Emergency Department (DSS)
EDB	Medicare Enrollment Database
EDI	Electronic Data Interchange
edit	Validation of data.
EDMS	Electronic Document Management System
EDP	Electronic Data Processing
EFT	Electronic Funds Transfer The payment of funds made by direct deposit to a provider's bank account.
EHR	Electronic Health Record (See also EMR, Electronic Medical Record), a record of diagnoses, treatments and laboratory results stored in an electronic record for retrieval and use by authorized treatment professionals.
EIS	Executive Information System High level management reporting using graphical and tabular reports via the Decision Support System (DSS) to provide upper management data for accessing the overall scope and performance of the Medicaid program.
Eligible	As it pertains to Buy-In, it means that an individual has met certain qualifications.
eligibility file	A file that maintains pertinent data for each Medicaid eligible recipient.
eligibility verification	Refers to the process of validating whether an individual is determined to be eligible for health care coverage through the Medicaid program and/or a provider is qualified to provide services to the Medicaid population. Eligibility for the recipient and provider is determined by the state.

emancipation	When a minor has achieved independence from his or her parents, often by getting married before reaching age 18 or by becoming fully self-supporting.
EMR	Electronic Medical Record (See also EHR, Electronic Health Record), a record of diagnoses, treatments and laboratory results stored in an electronic record for retrieval and use by authorized treatment professionals.
encounter data	Detailed data about individual health care related services provided by a capitated managed care organization (MCO) or other state-designated managed care providers. Encounter data is equivalent to a standard Medicaid claim except that it is submitted to provide service delivery data to the Agency and is not eligible for reimbursement. MCO health care related services are those covered and reimbursed by a per member, per month capitated rate payment.
enhancements	Major MMIS system changes that are federally or state mandated and funded by CMS at an enhanced rate.
Entitled	As it pertains to Buy-In, it means that an individual has paid into the Social Security retirement system or has been determined disabled and, therefore, the benefit belongs to them.
EOB	Explanation of Benefits An explanation of denial or reduced payment included on the provider's remittance advice.
EOMB	Explanation of Medical Benefits The result of Medicare claims processing reported to a provider.
EOMB	Explanation of Medicaid Benefits A report of paid Medicaid claims reported to selected recipients for fraud and abuse purposes.
EQRO	External Quality Review Organization
ESC	Error Status Code
evaluation	The in-depth review and analysis of contractor's proposals.
F	
FA	Fiscal Agent Refers to the Vendor operating FMMIS. A contractor who processes Medicaid provider claims for payments and performs certain other related functions as an agent for the state.
FACTS	Fraud and Abuse Tracking System Developed by third party Vendor and used by Medicaid Program Integrity.
FADS	Fraud and Abuse Detection Subsystem
FAL	Functional Area Lead
FAO	Fiscal Agent Operations
FDLE	Florida Department of Law Enforcement
FFP	Federal Financial Participation The percentage amount contributed by the federal government towards a category of costs in the Florida Medicaid program.
FFS	Fee-for-Service
FG/PG	Facilitator Guide/Participant Guide
FHK	Florida Healthy Kids
FHS	First Health Services
Field Office	The AHCA office that Fields Service Representatives visit to facilitate Provider education, provide documentation, and research issues.

FIP	Florida Interactive Portal
FLORIDA	Florida On-Line Recipient Integrated Data Access System An integrated automated system for TANF, Food Stamps, Medicaid Eligibility, Child Support Enforcement, and Project Independence.
FMAP	Federal Medical Assistance Percentage
FMMIS	Florida Medicaid Management Information System Florida Medicaid claims processing system.
FMMIS/DSS	Florida Medicaid Management Information System/Decision Support System FMMIS and DSS designed, developed, and implemented by the Contractor to meet all of the business requirements contained in this RFP.
FRAES	Florida Regulatory and Enforcement System. Old facility licensure system replaced by License Ease. FRAES is a comprehensive database management system that offers the functionality to handle vast and complex data. This single application is designed to manage all phases of licensing, including complaint, inspection, legal cases and revenue management. This system also handles MediPass credentialing.
FrameMaker	Software used to produce systems and user documentation for FMMIS account. Commonly abbreviated as FM.
FREEDOM	Florida Rapid Entry to Data Online for Medicaid Name associated with current Medicaid DSS.
FTE workday	FTE workday is a unit of measurement that describes the eight hours a full-time employee works in a day.
FTP	File Transfer Protocol
functional equivalence	The ability of a solution not defined in the federal General System Design (GSD) for Medicaid systems to meet the business requirements of the GSD.
FY	Fiscal Year State: the twelve-month period beginning July 1 and ending June 30. Federal: the twelve-month period beginning October 1 and ending September 30.
G	
GAAP	Generally Accepted Accounting Principles
Gainwell Technologies	Fiscal Agent as of April 1, 2017
GIS	Geographical Information Systems Software programs that allow data to be displayed spatially.
GPCI	Geographic Practice Cost Index Components which reflect the physician's work, practice expense, and malpractice expense.
group health plan	An employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that: <ul style="list-style-type: none"> • Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or • Is administered by an entity other than the employer that established

	and maintains the plan. <i>Note: Also see the definition of health plan.</i>
GUI	Graphical User Interface
H	
HCFA	The Health Care Financing Administration within the Department of Health and Human Services that administered Medicare and Medicaid policies. HCFA is now called the Centers for Medicare and Medicaid Services (CMS).
HCPCS	Healthcare Common Procedure Coding System A coding system designed by CMS that describes the physician and non-physician patient services covered by Medicaid and Medicare programs, used primarily to report reimbursable services provided to patients.
HDD	Hard disk drive
health care	The care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following: <ul style="list-style-type: none"> • Preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and • Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.
health care clearinghouse	A public or private entity, including a billing service, repricing company, community health management information system or community health information system, and “value added” networks and switches, that does either of the following functions: <ul style="list-style-type: none"> • Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or • Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.
health care operations	Health care operations means any of the following activities to the extent that the activities are related to covered functions: <ol style="list-style-type: none"> 1. Conducting quality assessment and improvement activities including: <ul style="list-style-type: none"> • Outcome evaluation and development of clinical guidelines provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities; Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination; • Contacting of health care providers and patients with information about treatment alternatives; and • Related functions that do not include treatment. 2. Licensing, credentialing, and training activities including: <ul style="list-style-type: none"> • Reviewing the competence or qualifications of health care professionals; • Evaluating practitioner and provider performance; Evaluating health

	<p>plan performance;</p> <ul style="list-style-type: none"> • Conducting training programs in which students, trainees, or practitioners in areas of health care learn, under supervision, to practice or improve their skills as health care providers; • Training of non-health care professionals; and • Accreditation, certification, licensing, or credentialing activities. <p>3. Contract activities including:</p> <ul style="list-style-type: none"> • Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits; and • Ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of Section 164.514(g) of the HIPAA regulations are met, if applicable. <p>4. Conducting or arranging for medical review, legal services, and auditing functions.</p> <p>5. Fraud and abuse detection and compliance programs.</p> <p>6. Business planning and development, such as:</p> <ul style="list-style-type: none"> • Conducting cost-management and planning related analyses related to managing and operating the entity; • Formulary development and administration; and • Development or improvement of methods of payment or coverage policies. <p>7. Business management and general administrative activities of the entity, including, but not limited to:</p> <ul style="list-style-type: none"> • Management activities relating to implementation of and compliance with the HIPAA requirements; • Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected information is not disclosed to such policy holder, plan sponsor, or customer; • Resolution of internal grievances; • Consistent with the applicable requirements of the HIPAA privacy rule, creating de-identified health information; • Keeping applicants and recipients informed about services, benefits, appointments, and treatment options in accordance with the federal Medicaid and HIPAA privacy rule.
health care provider	<p>A provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.</p>
health information	<p>Health information means any information, whether oral or recorded, in any form or medium, that:</p> <ul style="list-style-type: none"> • Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and • Relates to the past, present, or future physical or mental health or

	condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.
health insurance issuer	As defined in section 2791(b)(2) of the PHS Act, 42 U.S.C. 300gg-91(b)(2) and used in the definition of health plan, means an insurance company, insurance service, or insurance organization (including an MC) that is licensed to engage in the business of insurance in Florida and is subject to state law that regulates insurance. It does not include a group health plan.
Health Maintenance Organization (MC)	As defined in section 2791(b)(3) of the PHS Act, 42 U.S.C. 300gg-91(b)(3) and used in the definition of health plan, MC (Managed Care) means a federally qualified MC, an organization recognized as an MC under state law, or a similar organization regulated for solvency under state law in the same manner and to the same extent as an MC (note: formerly referred to as HMO).
HOM	Health Outcome Measurement
Health Oversight Agency	Health oversight agency means an agency or authority of the United States, Florida, a political subdivision of Florida, an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.
Health plan	<p>An individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)). Health plan includes the following, singly or in combination:</p> <ul style="list-style-type: none"> • Group health plan; • Health insurance issuer; • MC; • Part A or Part B of the Medicare program under Title XVIII of the Act; • The Medicaid program under Title XIX of the Act, 42 U.S.C. 1396, et seq.; • An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)); • An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy; • An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers; • The health care program for active military personnel under Title X of the United States Code; • The veteran's health care program under 38 U.S.C. chapter 17; • The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in 10 U.S.C. 1072(4)); • The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.; • The Federal Employees Health Benefits Program under 5 U.S.C.

	<p>8902, et seq.;</p> <ul style="list-style-type: none"> • An approved state child health plan under Title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq.; • The Medicare + Choice program under Part C of Title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28; • A high-risk pool that is a mechanism established under state law to provide health insurance coverage or comparable coverage to eligible individuals; • Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)); <p>Health plan excludes:</p> <ul style="list-style-type: none"> • Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and • A government-funded program (other than the ones listed above) whose principal purpose is not providing or paying the cost of health care; or whose principal activity is the direct provision of health care to persons or the making of grants to fund the direct provision of health care to persons.
HHS	The Federal Department of Health and Human Services.
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996 A federal law that includes requirements to protect patient privacy, to protect security of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.
HIPP	Health Insurance Premium Payment
HME	Agency for Health Care Administration's (AHCA) Home Medical Equipment Unit
HOM	Health Outcome Measurement
hospitalist	A physician who specializes in treating hospitalized patients of other physicians in order to minimize the number of hospital visits by other physicians
HP/HPE	Hewlett Packard Enterprise (Former Fiscal Agent) - now Gainwell Technologies
HQA	Health Quality Assurance AHCA's bureau of Health Quality Assurance and Managed Care Administration.
HTML	Hypertext Markup Language A standardized computer language for displaying information in web browser screens across various operating systems and platforms.
I	
ICD-9-CM	International Classification of Disease, Ninth Edition, Clinical Modification A classification and coding structure of diseases used by the state and healthcare community to describe patients' conditions and illnesses and to

	facilitate the collection of statistical and historical data.
ICD-10	International Classification of Disease, Tenth Edition A classification and coding structure of diseases used by the state and healthcare community to describe patients' conditions and illnesses and to facilitate the collection of statistical and historical data.
ICF/DD	Institutional Care Facility for the Developmentally Disabled
ICN	Image Control Number A unique serial number applied to each imaged document stored in FMMIS. Several ICNs may be associated with a single Transaction Control Number and non-claim documents may have an ICN as their sole control number.
ICP	Institutional Care Program
ICR	Intelligent Character Recognition (ICR) scanning technology
ID	Identification number
IEVS	Income Eligibility Verification System
IG	Inspector General's Office (State of Florida)
immediately	Within one hour
IMS	Issue Management System
individual	The person who is the subject of protected health information.
individually identifiable health information (IIHI)	<ul style="list-style-type: none"> Is a subset of health information, including demographic information collected from an individual; Is created or received by a health care provider, health plan, employer, or health care clearinghouse; Relates to the past, present, or future physical or mental health or condition of an individual; The provision of health care to an individual; The past, present, or future payment for the provision of health care to an individual; and Identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
intermediary	Private insurance organization under contract with the federal government handling Part A Medicare claims.
internal stakeholders	All persons on the project team with an interest in the outcome of the project, including the Gainwell Implementation Team, state and fiscal agent staff, contractors.
IQIM	Integral Quantitative Information Measure
IQIR	Incoming Quality Inspection Rejection
IQIS	Inpatient Quality Indicators
IRS	Internal Revenue Service (Federal)
ISDM	Information Systems Development Methodology A formal process to organize, execute, and document the development of information systems projects, approved by the State to manage the work and produce artifacts appropriate to the platforms being used for development.
ISO 9002:200	International Organization for Standardization
IT	Information Technology Any equipment, or interconnected system(s) or subsystem(s) used in the automatic acquisition, storage, manipulation, management, movement, control, display, switching, interchange, transmission, or reception of data or information by the Agency. IT includes computers, ancillary

	equipment, software, firmware, and similar procedures, services (including support services), and related resources.
ITO	Information Technology Organization
J	
J2EE- JAVA2 PLATFORM, ENTERPRISE EDITION or J2EE	A standard for developing distributed Multi-tier architecture applications, based on modular components running on an application server. It uses several technologies, including JDBC and CORBA, and extends their functionality with Enterprise Java Beans, Java Servlets, Java Server Pages, and XML technologies.
JAD	Joint Application Design
JCA - J2EE CONNECTOR ARCHITECTURE	A standard that allows J2EE (Java 2 Platform, Enterprise Edition) application servers to reach enterprise information systems (EIS).
JMS	Java Message Service - API is a messaging standard that allows application components based on the Java 2 Platform, Enterprise Edition (J2EE) to create, send, receive, and read messages. It enables distributed communication that is loosely coupled, reliable, and asynchronous.
Jukebox	A device that holds multiple optical discs and one or more disc drives, and can swap discs in and out of the drive as needed. The robotics mechanism, in simple terms, works just like a CD auto-changer. The optical disk is a “once write multiple reads” compact disc.
L	
LAN	Local Area Network Backbone and Network Servers
law enforcement official	An officer or employee of any agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, who is empowered by law to: 1. Investigate or conduct an official inquiry into a potential violation of law; or 2. Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.
LicenseEase	A new facility licensure system in 2002, which replaced FRAES. It manages all phases of licensing, including complaint, inspection, legal cases, and revenue management. This system also handles MediPass credentialing.
limited data set	Is protected information that excludes the following direct identifiers of the applicant/beneficiary or of his or her relatives, employers, or household members: <ol style="list-style-type: none"> 1. Names; 2. Postal address information, other than town or city, state, Zip Code; 3. Telephone numbers; 4. Fax numbers; 5. Email addresses; 6. Social Security numbers; 7. Medical record numbers; 8. Health plan beneficiary numbers; 9. Account numbers; 10. Certificate/license numbers; 11. Vehicle identifiers and serial numbers, including license numbers;

	<p>12. Device identifiers and serial numbers;</p> <p>13. Web Universal Resource Locators (URLs);</p> <p>14. Internet Protocol (IP) address numbers;</p> <p>15. Biometric identifiers, including finger and voice prints; and</p> <p>16. Full face photographic images and any comparable images.</p>
LMS	Learning Management System
Lock-in	A FMMIS function in which a Medicaid recipient receives certain benefits from a single, identified source. Lock-in is most used in Pharmacy Benefits Management to require a potentially abusive recipient to pick up prescriptions at a certain pharmacy only. Lock-in is used in managed care to require a recipient to receive care through a certain MC or service network for a set period of time.
LTC	Long Term Care
M	
MACRA	Medicare Access and CHIP Reauthorization Act
Managed Care (MC)	Systems of care designed to improve recipients' access to health care and continuity of care, while reducing the overall costs of care.
MAC	Maximum Allowable Cost
MAPIR	Medical Assistance Provider Incentive Repository
marketing	<p>To make a communication about a product or service, a purpose of which is to encourage recipients of the communication to purchase or use the product or service. Marketing excludes a communication made to an individual:</p> <ul style="list-style-type: none"> • To describe the entities participating in a health care provider network or health plan network, or to describe if, and the extent to which, a product or services (or payment for such product or service) is provided by a covered entity or included in a plan of benefits; • For treatment of that individual; or • For case management or care coordination for that individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to that individual.
MAR	Management and Administrative Reporting
MB	Megabyte
MBI	Medicare Beneficiary Identifier
MCM	Medicaid Contract Management (now known as Medicaid Fiscal Agent Operations or MFAO)
MCO	<p>Managed Care Organizations</p> <p>Specific to Florida Medicaid, these organizations include the current and future MC plans. It is expected that the number and type of Florida Medicaid MCOs will continue to grow.</p>
MCU	Managed Care Updates
MDS	Minimum Dataset
Medicaid	The federal medical assistance program as described in Title XIX of the Social Security Act.
Medicaid programs	See Benefit plans and Assignment plans.
Medicaid Information Technology	MITA. An initiative by the federal Centers for Medicare and Medicaid Services to modernize Medicaid Management Information Systems operated by the Agency by promoting greater interoperability with other

Architecture	systems, use of Commercial-Off-The-Shelf software, reusable programs and systems, and system analysis that allows business needs to drive system development.
Medicaid Reform	Proposed reform efforts to contain the cost of the Medicaid program in Florida.
Medicare	The federal health care program as described in Title XVIII of the Social Security Act. Part A covers hospitalization and Part B covers medical insurance.
MEDP	SMMC aid category for enrollees with Medicaid Pending – The individuals who apply for the LTC Program in order to receive home and community- based services and who meet medical eligibility requirements. These individuals can choose to receive services before being determined financially eligible for Medicaid by the Department of Children and Families.
MediPass	Medicaid Physician Access System A Medicaid primary care case management program designed to assure adequate access to primary care, reduce inappropriate utilization, and control program costs.
MEDS-AD	Medicaid for Aged or Disabled
MEUPS	Medicaid Enterprise User Provisioning System
MEVS	Medicaid Eligibility Verification System
MFAO	Medicaid Fiscal Agent Operations, formerly Medicaid Contract Management (MCM)
MFCU	Medicaid Fraud Control Unit A section under the Florida Attorney General that investigates potential Medicaid fraud and abuse.
Mhz	Megahertz
milestone	The measuring point used to review and approve progress, to authorize continuation of work, and, depending on the terms of the contract, to pay for work completed.
“Minimum Necessary Required”	Limiting the use of disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. In other words, you only have access to the minimum amount of PHI necessary to perform your defined work function.
MIS	Managed Information System
MITA	Medicaid Information Technology Architecture
mitigation plan	An action taken to reduce or eliminate the probability and impact of an identified risk before it occurs.
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MMA	Managed Medical Assistance
MMIS	Medicaid Management Information System Medicaid claims processing and information system.
MM P code	The three-letter code used to identify women eligible for Medicaid due to pregnancy.
modification	Routine FMMIS system changes that are identified throughout the life of the contract, documented on the Customer Service Request (CSR) form, and submitted to the contractor for design, programming, and implementation.
MOU	Memorandum of Understanding
MPI	Medicaid Program Integrity Unit responsible for Fraud and Abuse Detection under the Inspector General’s Office.

MPN	Minority Physician Network
MQC	Medicaid Quality Control
MS	SSI Medicaid For SSI Direct Assistance Recipients
MSAS	Medicaid Service Authorization System Agency-developed tracking system for handling all service authorizations. Medicaid Field Offices use this system to track all requested and approved service authorizations.
MSC	Management Steering Committee
N	
NACOS	Network Access Control Online System. Creates online or batch requests for any request for CA-ACF2, RACF, VM:SECURE, and TOP SECRET security platform applications.
NCCI	National Correct Coding Initiative
NCPDP	National Council of Prescription Drug Programs
NDC	National Drug Code
nominated risk	A team member or stakeholder has suggested that a possible risk be considered, but the risk committee has not yet accepted this as a risk item; the risk item is tentatively entered into the Risk Identification Log.
NEO Book	New Employee Orientation book
NET	Non Emergency Transportation service
NIC	Network interface card
NPDB	National Practitioner Database
NPI	National Provider Identifier
NPS	National Provider System
O	
OCR/ICR	Optical Character Recognition (OCR)/Intelligent Character Recognition (ICR) scanning technology
OIG	Office of Inspector General
organized health care arrangement	<ul style="list-style-type: none"> • A clinically integrated care setting in which individuals typically receive • health care from more than one health care provider; • An organized system of health care in which more than one covered entity participates, and in which the participating covered entities hold themselves out to the public as participating in a joint arrangement and participate in joint activities that include at least one of the following: <ul style="list-style-type: none"> ○ Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf; ○ Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or ○ Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

	<ul style="list-style-type: none"> • A group health plan and a health insurance issuer or MC with respect to such group health plan, but only with respect to protected health information created or received by such health insurance issuer or MC that relates to individuals who are or who have been participants or beneficiaries in such group health plan; • A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or • The group health plans described above and health insurance issuers or MCs with respect to such group health plans, but only with respect to protected health information created or received by such health insurance issuers or MCs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.
OIR	Office of Insurance Regulation
online	Interaction between a user operating a cathode ray tube (CRT), personal computer, or point of service (POS) device to send and receive information on a video display via a telecommunications network to a central computer processing unit (CPU).
OS	Operating system
OSCAR	Online Survey Certification and Reporting The federal file which contains CLIA certified providers and their classifications. The interface loads and verifies the CLIA provider number, status, and specialties for which a provider is approved and can deny claims based upon CLIA specialties and subspecialties found on the OSCAR file.
overpayment	Payment made to a provider in excess of the amount allowed under the Medicaid State Plan guidelines.
P	
PAG	Physician Advocacy Group
paid claim	A claim that has resulted in the provider being reimbursed for some dollar amount or a zero paid amount.
password	Refers to confidential authentication information composed of a string of characters.
payment	<p>The activities that relate to the individual to whom health care is provided undertaken by:</p> <ul style="list-style-type: none"> • A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or • A health care provider or health plan to obtain or provide reimbursement for the provision of health care. <p>Payment activities include, but are not limited to:</p> <ul style="list-style-type: none"> • Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts); • Adjudication or subrogation of health benefit claims; and • Risk adjusting amounts due based on enrollee health status and demographic characteristics; • Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing; • Review of health care services with respect to medical necessity,

	coverage under a health plan, appropriateness of care, or justification of charges; and <ul style="list-style-type: none"> Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services.
PBM	Pharmacy Benefit Management
PCCM	Primary Care Case Management
PCP	Primary Care Physician or Primary Care Providers
PDCS	Prescription Drug Card System Claims processing system used by the incumbent fiscal agent to process all pharmacy claims with nightly data passed to FMMIS (same as PBM)
PDHP	Prepaid Dental Health Plan
PDL	Preferred Drug List
PECOS	Provider Enrollment Chain and Ownership System
PES	Provider Electronic Solutions Proprietary MS Windows-based software distributed free of cost to FL Medicaid providers to enable them to submit electronic claims by batch.
personal representative	A person who manages the legal affairs of another, such as a power of attorney or executor.
PHI	See Protected Health Information
PHP	Prepaid Health Plan
PHS	Public Health Service
PII	Personally Identifiable Information
PITR	Point in Time Restore
PMA	Public Medical Assistance
PMATF	Public Medical Assistance Trust Fund
PMBOK™	Project Management Body of Knowledge A library of project management skills, tools, and standards used by the Project Management Institute to measure and certify Project Management Professionals.
PMHP	Prepaid Mental Health Program A waiver program to capitate costs of certain mental health services currently operated in two AHCA areas.
PMI	Project Management Institute A body that certifies Project Management Professionals.
PMI PMBOK	Project Management Institute Project Management Body of Knowledge
PMO	Program Management Office
PMP	Project Management Professional or Primary Medical Provider
POA	Power of Attorney
POS	Place of Service Sometimes used to mean “Point of Sale” for Pharmacy.
Premium	A dollar amount a person has to pay for insurance coverage.
prime contractor	A contractor who contracts directly with the state for performance of the work specified in this RFP.
prioritized risk	A risk that has been evaluated for probability of occurrence, potential impact, and risk exposure calculated leading to assigning a priority based on risk exposure.
PRO	Peer Review Organization
procurement library	The collection of FMMIS documentation, provider policy manuals, and general information related to the Florida Medicaid program and the Florida MMIS.
proDUR	Processing and prospective drug utilization review.

Program code	See Aid Categories.
project level risk	A risk that can have a global impact on the project.
Protected Health Information (PHI)	<p>Protected health information (PHI) is the individually identifiable health information that is communicated in the following ways:</p> <ul style="list-style-type: none"> • Transmitted by electronic media, which includes Internet, Extranet, leased lines, dial-up lines, private networks, magnetic tape, disk, or compact disc (45 CFR 162.103); • Maintained in any electronic media; or • Transmitted or maintained in any other form or medium, which include oral communication or paper. <p>This definition excludes individually identifiable health information in:</p> <ul style="list-style-type: none"> • Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; • Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and • Employment records held by a covered entity in its role as employer.
provider	A person, organization or institution that provides health care related services and is enrolled in the Florida Medicaid program.
provider class	An extrapolation of provider type, category of service, geographic location and other factors that specify the characteristics used to distinguish different kinds of providers in the system.
provider handbook	Provider manuals that contain the state's program specific coverage, limitation, and reimbursement policies.
Provider Field Services Representatives	The Provider Field Services Representatives are responsible for assisting providers through onsite visits and education activities, handling telephone and written inquiries, resolving problem claims, and communicating provider issues to Gainwell management and AHCA.
PSN	<p>Provider Service Network</p> <p>A network of providers under separate contract to provide services to a list of Medicaid recipients and share in cost savings for efficient patterns of care.</p>
psychotherapy notes	<p>Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.</p> <p>Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.</p>
Public Health Authority	Is an agency or authority of the United States, a state, a political subdivision of a state or territory, an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of the public agency or its contractors, persons, or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.
Q	

QA	Quality Audit
QII	Qualified Individual 1 A category of Medicaid in which the only service the recipient is eligible for is to have their Part B Medicare premium paid. This category was previously known as PBMO.
qualified risk	An urgent priority, high priority or medium priority risk, requiring a risk response plan.
R	
RA	Remittance Advice The statement mailed to a provider detailing the claim charges pending, paid, or denied. A summary of payments produced by FMMIS along with provider reimbursement. RAs are sent to providers along with checks or EFT.
RAID	Redundant Arrays of Independent Disks
RAM	Random Access Memory
RBRVS	Resource Based Relative Value Scale
recipient	A person who has been determined to be eligible for assistance in accordance with the state plan(s) under Title XIV and Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, and/or Title IV of the immigration and Nationality Act.
record	Any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
reimbursement handbook	Provider manuals that contain billing instruction for reimbursement by Florida Medicaid.
rejected claim	A claim that contains errors found during screening, such as missing provider ID or other key data elements, or has some conflicting information that will impede the proper adjudication through the automated system. Such claim is returned to the responsible provider without being entered into FMMIS.
Relates to the Privacy of Individually Identifiable Health Information	With respect to a state law, that the state law has the specific purpose of protecting the privacy of health information or affects the privacy of health information in a direct, clear, and substantial way.
Remittance Advice (RA)	The statement mailed to a provider detailing the claim charges pending, paid, or denied. A summary of payments produced by FMMIS along with provider reimbursement. RAs are sent to providers along with checks or EFT.
Remittance Voucher	The statement mailed to a provider detailing the claim charges pending, paid, or denied. A summary of payments produced by MMIS along with provider reimbursement. RVs are sent to providers along with checks or EFT.
Replacement Medicaid System	FMMIS The term used in this RFP to describe the new system that the contractor is to develop for the State of Florida; the system must be certifiable as meeting the requirements of Section 1903(r) of the Social Security Act.
Required by Law	A mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law. The HIPAA definition includes, but is not limited to:

	<ul style="list-style-type: none"> • Court orders and court-ordered warrants; • Subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; • A civil or an authorized investigative demand; • Medicare conditions of participation with respect to health care providers participating in the program; and • Statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits. <p><i>Note: In order for Medicaid protected information to be disclosed, even if required by law as defined above, the disclosure must be allowable under the federal Medicaid regulations.</i></p>
research	A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.
Residual Risk	Risk remaining after a risk mitigation action has been implemented.
RetroDUR	Retroactive Drug Utilization Review
RFP	Request for Proposal The document that describes to prospective proposers the requirements of the fiscal agent, FMMIS, terms and conditions and technical information.
risk	A risk is an uncertain event or condition that, if it occurs, has a positive or negative effect on the project objective.
risk management	Systematically thinking about potential negative outcomes before they happen and setting up processes that will avoid them, minimize their impact, or help you cope with their impact.
Risk management log	A centralized repository for documenting and tracking project risks.
RMP	Risk Management Plan
ROPA	Referring, Ordering, Prescribing, and Attending Providers
RPICC	Regional Perinatal Intensive Care Center
RRB	Railroad Retirement Board
RTD	Return to District
RTP	Return to Provider
RTS	Return to Submitter or Return to State
S	
SAN	Storage Area Network
SBI	Split Billing Indicator
scope of work	A document prepared by the requester and included in the requisition package, which delineates and fully describes the service to be performed or the required end result.
SCRUB	Remove an EFT record from the weekly payment file, essentially voiding the payment.
SDLC	Systems Development Life Cycle
SDX	State Data Exchange System The Social Security Administration's method of transferring SSI entitlement information to the state via tape.
Secretary of HHS	Refers to the Secretary of Health and Human Services or any other officer or employee of HHS to whom the authority involved has been delegated.

service authorization	The approval required from a designated authority for reimbursement of certain Medicaid services.
SIXT	SMMC Aid category for enrollees who have lost Medicaid eligibility for up to sixty days from the date of ineligibility. The SIXT aid category allows recipient coverage to continue during loss of eligibility.
SLC 3	System Life Cycle
SMAC	State Maximum Allowable Cost
small health plan	A health plan with annual receipts of \$5 million or less.
SLMB	Special Low-income Medicare Beneficiaries A category of Medicaid where the only service the recipient is eligible for is to have their Part B Medicare premium paid.
SME	Subject Matter Expert
SMMC	Statewide Medicaid Managed Care
SOA	Service Oriented Architecture
SOAP	SOAP (Standard Object Access Protocol) A light-weight protocol for exchanging messages between computer software, typically in the form of software componentry. The word object implies that the use should adhere to the object-oriented programming paradigm.
SOLQ	State Online Query
source systems	Systems or data files outside FMMIS that supply data to FMMIS to be used in various business processes. There are many source systems, including the FLORIDA System operated by the Department of Health, BENDEX, and SSX data from the Social Security Administration.
spenddown	The Medically Needy program requires that an individual incur medical expenses equal to his/her share of cost amount, also known as the spenddown amount, in order to become eligible for Medicaid. Medicaid is federally prohibited from reimbursing providers any portion of a recipient's spenddown amount; however, share of the cost information and medical expenses are currently tracked on the state's Medicaid eligibility system. Spenddown is the amount that a recipient pays before Medicaid will start reimbursing for the claims/services.
SSA	Social Security Administration The federal organizational unit within DHHS that determines eligibility for various federally-administered programs.
SSI	Supplemental Security Income
SSN	Social Security Number
SSNRI	Social Security Number Removal Initiative
standard	Refers to a rule, condition, or requirement describing the following information for products, systems, services, or practices with respect to the privacy of individually identifiable health information: <ul style="list-style-type: none"> • Classification of components; • Specification of materials, performance, operations; or • Delineation of procedures.
Standard Setting Organization (SSO)	An organization accredited by the American National Standards Institute that develops and maintains standards for information transactions or data elements, or any other standard that is necessary for, or will facilitate the implementation of, this part.
state law	A constitution, statute, regulation, rule, common law, or other state action having the force and effect of law.

statutes	Laws passed by Congress or a state legislature and signed by the President or the Governor of a state, respectively, that are codified in volumes called “codes ” according to subject matter.
subcontractor	Any entity contracting with the Prime Contractor to perform services or to fulfill any of the requirements requested in this RFP or any entity that is a subsidiary of the Prime Contractor that performs the services or fulfills the requirements requested in this RFP.
SURS	Surveillance and Utilization Review Subsystem Part of the current FMMIS but was replaced by a client service application and data mart in the DSS in 2001.
SVES	State Eligibility Verification System
system documentation	Documents that contain the technical description of the configuration, components, and operation of FMMIS or DSS.
T	
T-MSIS	Transformed Medicaid Statistical Information System
TANF	Temporary Assistance for Needy Families
TCN	Transaction Control Number An internal control number assigned to each claim as the fiscal agent for processing receives it. The TCN is used in both FMMIS and PBM and is different in PBM.
TDD	Technical Design Document, includes technical aspects of FMMIS technical areas as documented on iTRACE.
TFAL	Technical Functional Area Lead
TPA	Third Party Administrator
TPL	Third Party Liability A situation in which a claim submitted as a result of an accident or injury where another individual or organization may be responsible for payment or in which a recipient has health insurance resources other than Medicaid or Medicare which are responsible for at least partial payment of a claim. The TPL Subsystem identifies claims where liability potentially exists. TPL includes private healthcare carriers, Medicare, and other third-party resources of Medicaid recipients, and ensures that Medicaid is the payer of last resort.
trading partner	An external entity, such as a third-party insurer, with whom the covered entity does business (in contrast, a business associate is an entity that performs certain business functions for a covered entity). The same entity can be a Medicaid trading partner for some purposes and a Medicaid business associate for other purposes.
treatment	The provision, coordination, or management of health care and related services by one or more health care providers, including: <ul style="list-style-type: none"> • The coordination or management of health care by a health care provider with a third party; • Consultation between health care providers relating to a patient; or • The referral of a patient for health care from one health care provider to another.
TRICARE	The US Government program that provides insurance to military dependents and retirees. (Previously known as CHAMPUS)
trigger (PMI definition)	A symptom or warning sign indicating that a risk has occurred or is about to occur. Some triggers may be more serious or indicative than others.
U	
UAT	User Acceptance Testing

UCF	Universal Claim Form The NCPDP standard paper claim form for pharmacy claims.
UPIN	Unique Provider Identification Number.
use	With respect to individually identifiable health information means the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.
Use case	Use cases define the user's interaction with FMMIS.
user	Any individual or a group identified by the state as the persons authorized to use all or parts of FMMIS functions. A user could also be a DSS User.
V	
VCTL	Version control system that is present on interprocess communication (IPC) mainframes.
vendor	Any responsible source that provides a supply or service.
W	
WAN	Wide Area Network Connection between two local area networks (LANs).
WBS	Work Breakdown Structure A detailed plan used to complete and track a project. The WBS identifies every task in the project, estimates time and resource requirements, identifies predecessor and successor tasks, identifies the critical path, and is used to compare to actual project performance.
WebEx	Online training environment (distance learning tool) as of 4/1/2017.
Work Product Review	WPR. The review conducted by QA reviewer, owner/author, and appropriate specialists prior to submission of a document to the State for approval.
workday	A day scheduled for regular state of Florida employees to work, Monday through Friday except holidays observed by regular state of Florida employees. Time frames in the Request for Proposal (RFP) requiring completion with a number of workdays shall mean by 5:00 p.m. Eastern Time on the last workday.
WSM	Web Services Manager
X	
XML	Extensible Markup Language Designed to improve the functionality of the web by providing more flexible and adaptable information identification. XML is actually a meta language-a language for describing other languages-which allows users to design their own customized markup languages for limitless different types of documents.
XSL/XSLT	(XSL) Extensible Style sheet Language (XSLT) Extensible Style sheet Language Transformations A language for transforming XML documents into other XML documents. XSLT is designed for use as part of XSL, which is a style sheet language for XML. In addition to XSLT, XSL includes an XML vocabulary for specifying formatting. XSL specifies the styling of an XML document by using XSLT to describe how the document is transformed into another XML document that uses the formatting vocabulary.

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