

Glossary

Authorization	A process by which prior-approval is required for specific services before they are provided to the recipient. <i>Important Note:</i> A Medicare beneficiary does not require prior authorization for any service.
Beneficiary	The individual whose benefits are covered by the carrier.
Carrier	Any entity that has a responsibility for the financial coverage of health care for a beneficiary. This includes commercial as well as governmental entities.
COB	Coordination of Benefits. The process by which multiple carriers are involved in the payment for services to a beneficiary.
Co-Insurance	A type of beneficiary responsibility for a covered service involving a percentage of a claim. For example, at 20% coinsurance on a \$100 claim, requires the beneficiary to pay \$20 for the covered service.
Commercial Carrier	A private insurance or Managed Care Organization providing healthcare to a beneficiary
Copay	A flat rate that is the responsibility of the beneficiary. For example, a \$25 copay on prescription drugs means that the beneficiary is responsible for paying \$25 for each prescription.
Deductible	When a beneficiary is responsible for the very first component of care in a period of time such as a year. For example, a beneficiary who has a \$500 deductible for inpatient care is responsible for paying the first \$500 in inpatient costs incurred in the benefit year. Deductibles can have a complicated nature in that they may be applied to any timeframe and sometimes are reset in gaps between occurrences. Medicare beneficiaries have complex structures for inpatient care and need to be reviewed on an individual basis.
EOB	Explanation of Benefit. An EOB is a document sent to the provider or the beneficiary documenting a claims payment. An EOB is sent by the paying carrier. A carrier (including Medicaid) will require that EOBs are received from all other, higher carriers, prior to considering their payment responsibility.

Means Testing	Means Testing for Priority Population Beneficiaries is a financial test that is applied to an individual that does not qualify for Medicaid to determine what portion of benefits will be covered under the Priority Population segment. There are individuals who have the means to pay all or a portion of their YOUR CHOICE coverage and this test is used to determine the amount.
Medicaid Hotline	The information line at MDCH for all Medicaid questions is 1-800-723-8247.
Medicare Crossover	Also referred to as a Dual Eligible . A term used to identify a Medicaid beneficiary who also has Medicare coverage.
Medicare Part A	The Hospitalization component of Medicare coverage. All Medicare beneficiaries have Medicare Part A coverage.
Medicare Part B	The outpatient clinical component of Medicare coverage. This coverage is optional and must be purchased for a premium.
Medicare Part D	The new Medicare prescription drug coverage program. There is a monthly premium that varies depending on the Prescription Drug Plan that the beneficiary selects.
Payor of Last Resort	Medicaid is always the payor of last resort. All other benefits for the covered service must be exhausted prior to Medicaid payment.
Priority Population	The under insured population in the YOUR CHOICE program that do not qualify for Medicaid enrollment.
Spend-Down	A category of Medicaid participation in which the beneficiary is responsible for a portion of their health care costs before Medicaid begins.