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A. Quick Reference Guide

IEHP Quick Reference Guide

Main Number:	(909) 890-2000
Main Fax Number:	(909) 890-2002
Provider Relations Team:	(909) 890-2054
Provider Relations Fax:	(909) 890-2968
Eligibility:	
IEHP's Secure Provider Portal:	www.iehp.org
Member Services:	
IEHP Member Services Support:	(800) 440-IEHP (4347)
Enrollment Assistance:	(866) 294-IEHP (4347)
TTY Member Services:	(800) 718-IEHP (4347) or (909) 890-0731
TTY Enrollment Assistance:	(800) 720-IEHP (4347) or (909) 890-1623
After Hours Nurse Advice Line:	(888) 244-IEHP (4347)
Hours of Operation:	Monday – Friday 8:00 a.m. - 5:00 p.m.
IEHP's UM Staff and Physicians: (Provider inquires regarding authorization request, status and clinical decision and process)	Monday – Friday 8:00 a.m. - 5:00 p.m.
IEHP Web Site:	www.iehp.org
Provider Relations Team Email:	ProviderServices@iehp.org

Closed For:	New Years Day	Thanksgiving Day
	Martin Luther King, Jr. Day	Day After Thanksgiving
	Presidents' Day	Christmas Eve
	Memorial Day	Christmas Day
	Day Before Independence Day	New Year's Eve*
	Labor Day	

**IEHP will designate an "alternative holiday" each year.*

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B. Glossary

TERM	*DEFINITION*
AAO	American Academy of Ophthalmology.
AAP	American Academy of Pediatrics; national entity that issues guidelines on preventive services and other care guidelines for children; DHCS contract mandates that the preventive guidelines be followed by IEHP network PCPs.
ABMS	American Board of Medical Specialties; delineates board certification standards; used for credentialing purposes.
ABPS	American Board of Podiatric Specialties; issues board certification to qualifying practitioners; used for credentialing purposes.
Abuse	Abuse applies to practices that are inconsistent with sound fiscal, business, medical or recipient practices and result in unnecessary cost to a health care program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
ACIP	Advisory Committee on Immunization Practice; national entity that issues guidelines on immunizations; DHCS contract mandates that these guidelines be followed by IEHP network PCPs.
ADAAG	Americans with Disabilities Act Access Guidelines; establishes design requirements for the construction and alteration of facilities in the private and public sectors.
ADHC	Adult Day Health Care Center; see CBAS (Community Based Adult Services).
ADL	Activities of Daily Living
Advance Directive	A written legal document that details treatment preferences for any health care decisions when a Member is unable to speak for themselves. Examples of advance directives include (but not limited to): a living will, a Durable Power of Attorney form, a health care proxy, a Physician Orders of Life Sustaining Treatment (POLST), Five Wishes and surrogate decision maker. This document must comply with State and Federal law.
AEVS	Automated Eligibility and Verification System; DHCS phone system to verify eligibility for Medi-Cal recipients.
Agreement	Same as contract; signed document between IEHP and Providers outlining responsibilities of both parties, may be capitated or per diem.
AMA	American Medical Association; Largest association of Physicians, including MDs, DOs, and Medical Students in the United States.
AOA	American Osteopathic Association; an organization that licenses osteopathic physicians; it also accredits hospitals; used for credentialing and oversight purposes.
AOR	Provider Acknowledgment of Receipt (AOR); Provider and all appropriate staff attest that they have received and/or been trained on the information contained in the

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B. Glossary

TERM	*DEFINITION*
	Policy and Procedure Manual, Electronic Data Interchange (EDI) Manual (if applicable), IEHP Code of Business Conduct and Ethics, Guidelines for Care Management Training, General Compliance Training and Culture and Linguistic (C&L) Training.
AOR	Appointment of Representative per policy 16A2
Appointment Waiting Time	Means the time from the initial request for health care services by an enrollee or the enrollee's treating Provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting Providers.
ASC	Ambulatory Surgical Centers; also known as free-standing surgi-centers or outpatient surgery centers; a facility not under the license of a hospital; devoted primarily to the provision of surgical treatment to patients not requiring hospitalization; these facilities generally do not provide accommodation of treatment of patients for periods of 24 hours or longer.
Case Management	A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife, as the Medical Home, Coordination of carved out and linked services are considered basic case management services.
Bed Day	Same as Hospital Day; any period up to 24 hours, commencing at 12:00AM during which a Member receives inpatient hospital services.
Behavioral Health	Includes all mental health (psychiatric, psychological and behavioral disorders) and substance abuse disorders.
Benefit Year	The benefit year for Medi-Cal Members is July 1st through June 30th, annually.
BHICCI	Behavioral Health Integration Complex Care Initiative
BHT	Behavioral Health Therapy
Bi-annual	As used by IEHP; means twice yearly; synonymous with semi-annual.
BIC Card	Benefit Identification Card; issued to Medi-Cal recipients by DHCS; used to identify beneficiaries as Medi-Cal Members; does not guarantee eligibility.
CAP	Corrective Action Plan; written plan by a Provider to remedy deficiencies.

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B. Glossary

TERM	*DEFINITION*
Capitation	Monthly payment to Providers for pre-defined services; usually associated with HMOs and is paid regardless of services actually rendered; IEHP's capitation is a flat rate per member per month, based on the Aid code of the Member.
Care Coordination	Services which are included in Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.
CBAS	Community Based Adult Services; a DHCS licensed community-based day care program providing a variety of health, therapeutic and social services to those as risk of being placed in a nursing home. This program replaced the ADHC benefit as of October 1, 2012.
CBO	Community Based Organization; an entity providing resources and information on various programs, e.g., Catholic Services.
CCS	California Children's Services; Locally administered public health program that that assures the delivery of diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.
CCS-Eligible Condition	California Children's Services Eligible Condition; Physically handicapping condition defined in Title 22, California Code of Regulations Section 41800.
CDC	Centers for Disease Control Prevention
CDL	Contact Drug List
CDS	Controlled Dangerous Substance; similar to DEA certification; an authorization issued to physicians writing prescriptions for controlled substances; used for credentialing purposes.
CHDP Program	Child Health and Disability Prevention Program; State program which issues guidelines on pediatric preventive services; IEHP uses guidelines for its Well Child Program per State requirements.
CIN	Client Index Number; a nine digit alphanumeric number assigned to Medi-Cal Members by DHCS for Member identification.
CM	Case Management; a process whereby covered persons with specific health care needs are identified and a plan which efficiently utilizes health care resources is formulated and implemented to achieve the optimum patient outcome in the most cost-effective manner.
CMS	Centers for Medicare and Medicaid Services**;** federal regulatory body overseeing Medicare and Medicaid programs, of which California's Medi-Cal program is part; one of the regulatory bodies overseeing IEHP's operations.

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B. Glossary

TERM	*DEFINITION*
CMS-1500 Claim Form	A federally approved claim form that meets the Centers for Medicare and Medicaid Services health insurance information collection requirements
Clean Claim	A claim that can be processed without obtaining additional information from the provider of services or from a third party.
COB	Coordination of Benefits; a process followed when a Member has duplicate coverage whereby the total cost of care for the Member either paid or reimbursed does not exceed 100%.
Code 1 Medications	Medications that are restricted to specified medical conditions, age group, and/or other specific circumstances, and where the Pharmacist can override the rejecting claim at the point-of-sale, if the defined condition(s) are met.
COE	Center of Excellence
Cold-Call Marketing	Any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing (as identified within the definition of Marketing).
Complex Case Management	The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.
Comprehensive Medical Case Management Services	Services provided by a Primary Care Provider in collaboration with the Contractor to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
Contractor	Includes all contracted Providers and suppliers, First Tier Entities, Downstream Entities and any other entities involved in the delivery of payment for or monitoring of benefits.
Covered Services	Vision care services and materials that are described as benefits in the Member's Handbook and EOC.
CPSP	Comprehensive Perinatal Services Program; a Medi-Cal program that provides a model of enhanced obstetric services for eligible low-income, pregnant and postpartum women.
CPT	Physician's Current Procedural Terminology (CPT); a listing of descriptive terms and identifying codes compiled and maintained by the American Medical Association and used to report medical services and procedures.

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B. Glossary

TERM	*DEFINITION*
Credentialing	The process of ensuring Providers meet minimum standards including, but not limited to, clear and current licensing, board certification, malpractice coverage, adverse history including malpractice and disciplinary actions and equipment/instrumentation.
Credentialing Subcommittee	One of seven committees established by IEHP that reviews and approves practitioner's qualifications and credentials to participate in IEHP's network. It is a subcommittee of the QM Committee.
CSR	Certified Site Reviewer; A Physician or Registered Nurse trained and certified to conducted DHCS required Facility Site Review (FSR) and Medical Record Review (MRR) Surveys at Primary Care Provider (PCP) sites. Certified Site Reviewers can be designated as DHCS Certified Master Trainer (DHCS-CMT), DHCS Designated Plan Trainer (DHCS-DPT), or DHCS Certified Site Reviewer (DHCS-CSR).
CVO	Credentialing Verification Organization; an entity that performs pre-determined credentialing processes, such as primary source verifications.
Days	Unless otherwise stated, days always means calendar days; usually shown in lower case.
DDS	Department of Developmental Services; administers and oversees various State waiver programs which provide in-home and community-based care. Such programs are provided in lieu of institutionalization to Members with developmental disabilities, the aged, or those Members who are physically disabled or have AIDS.
DEA	Drug Enforcement Agency; federal agency that oversees the distribution and use of controlled substances; issues certificates to prescribing physicians allowing dispensing of controlled substances; used for credentialing purposes.
DHCS	Department of Health Care Services formerly DHS; State agency responsible for oversight of the Two-Plan Model Managed Care Program and IEHP's operations.
DHHS	United States Department of Health and Human Services protects the health of all Americans and fulfill that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services. DHHS or HHS provides guidance and information related to regulations concerning HIPAA.
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

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B. Glossary

TERM	*DEFINITION*
Disease Management	IEHP's Disease Management program, which is based on evidence-based clinical practice guidelines, is designed to identify Members with specific chronic diseases relevant to IEHP's membership and facilitate access to Providers, health education activities, and other specific services to improve Member health outcomes.
Dispensing Fee	The amount a doctor is paid for providing materials to a Member. The dispensing fee covers the fitting and dispensing of lenses and/or frames.
DMHC	Department of Managed Health Care; effective 7/1/00, formerly the Department of Corporations (DOC); one of the State regulatory bodies which oversees IEHP operations; regulates Knox-Keene Health Care Service Plans, which allows IEHP to operate as an HMO.
DOA	Delegation Oversight Audit; An onsite review of a Delegated IPAs Performance of delegated plan responsibilities.
Downstream Entity	Any party that enters into an acceptable written agreement below the level of the arrangement between an organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
DPA	Diagnostic Pharmaceutical Agent; a state certificate that grants the privilege to Optometrists to use certain medications for diagnostic purposes.
DPSS	Department of Public Social Services; State agency responsible for the administration of health and welfare benefits, including eligibility for Medi-Cal.
Early Start Program	California's early intervention program for infants and toddlers with disabilities and their families. See "Inland Regional Center."
ED	Emergency Department.
EFT	Electronic Funds Transfer; the mechanism by which capitation payments are made electronically to Providers by IEHP.
Encounter	Each visit a Member makes to a practitioner or Provider.
Encounter Data	Mandatory encounter data reported to IEHP by its Providers; includes detailed information on services provided to each Member in each month.
EOC	Evidence of Coverage; The agreement between IEHP and the Member which describes Covered Services, and which sets forth the terms and conditions of coverage and enrollment with IEHP.

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B. Glossary

TERM	*DEFINITION*
EPSDT	Early and Periodic Screening, Diagnosis and Treatment Supplemental Services; medically necessary services that may or may not be covered by Medi-Cal; available to Members 21 years of age or younger.
Explanation Codes	Codes used on the Remittance Advice (RA) to reflect claim adjustments made by IEHP.
FAME	Fiscal Intermediary Access to Medical Eligibility; a monthly and daily electronic transmission from DHCS, which contains eligibility and demographic data on IEHP Medi-Cal Members.
FFS	Fee-For-Service; a method of claims payment whereby the amount of reimbursement is determined by the type of service rendered by the provider of service; the amount of reimbursement is based on a set fee schedule that varies according to the type of services rendered.
First Tier Entity	Any party that enters into a written arrangement with an organization or contract applicant to provide administrative or health care services for an eligible individual.
Formulary	A continually updated list of medications immediately available to practitioners and Members. It contains information on co-payment requirements and the procedures for obtaining Code 1 and non-formulary medications.
FPC	Fraud Prevention Committee; IEHP's administrative committee that oversees all activities of its FPP.
FPP	Fraud Prevention Program; Developed to train IEHP staff and Providers to identify, deter, prevent and report suspected fraudulent activities.
Fraud	Fraud is intentional or knowing misrepresentation made by a person with the intent or knowledge that could result in some unauthorized benefit to him/herself or another person. It includes any portion that constitutes fraud under applicable Federal or State law.
Fraud, Waste and Abuse Program	Fraud, Waste and Abuse Program; Developed to train IEHP staff and Providers to identify, deter, prevent and report suspected fraudulent activities.
FSR	Facility Site Review; An assessment of a Primary Care Provider's (PCP) site, performed by a Certified Site Reviewer using state-mandated audit tools, prior to the Provider site participating in Medi-Cal Managed Care
FTP	File Transfer Protocol; method used to obtain and transmit Member eligibility and encounter data from/to IEHP.
Grievance	An oral or written expression of dissatisfaction regarding IEHP staff, policies or processes, our contracted Providers' staff, processes or actions, or any other aspect of health care delivery through IEHP, including quality of care concerns.

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B. Glossary

TERM	*DEFINITION*
HCAC	Health Care-Acquired Conditions
HCBS	Home and Community Based Services Waiver Program; DDS program providing in-home care to Members with developmental disabilities.
HEDIS	Healthcare Effectiveness Data and Information Set; a tool used by health plans to measure performance on important dimensions of care and service.
HCO	Health Care Options, a unit of DHCS; handles both enrollment and disenrollment of Medi-Cal recipients; sometimes used interchangeably with Maximus.
HHA	Home Health Agency; entities that provide a wide range of health and social services delivered at home to persons recovering from an illness or injury, or persons with disabilities or chronic illness.
HHP	Health Homes Program; a clinical service delivery model available to s small subset of Medi-Cal Members that focuses on providing individualized, whole-person care by a trained, integrated care team that works in close connection with the Member's Primary Care Physician (PCP).
HMO	Health Maintenance Organization; provides health care services to enrolled Members for a fixed sum of money, paid in advance for a specified period of time; usually associated with managed care.
Hospital Day	Same as bed day.
HRA	Health Risk Assessment (HRA); A survey tool that is based on regulatory standards, stakeholder and consumer's input that assesses the medical, cognitive, functional needs and psychosocial status of the Members.
ICD-10-CM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Clinical Modification. IEHP is in the 10th Clinical Modification. This is the system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States.
ICF-DD	Intermediate Care Facilities for Developmentally Disabled
ICP	Individualized Care Plan; treatment and intervention program for pregnant Members developed by OB; required by IEHP.
ICT	Interdisciplinary Care Team; A team comprised of the Primary Care Physician (PCP) and Nurse Care Manager, and other Providers at the direction of the Member, that works with the Member to develop, implement and maintain their individualized care plan (ICP).

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B. Glossary

TERM	*DEFINITION*
IEHP Identification Card	Issued by IEHP to Members; identifies PCP and Hospital affiliations; used for identifying beneficiaries as IEHP Members; does not guarantee eligibility.
IEHP Vision Provider	An Optometrist, Ophthalmologist or Optician who has signed a contract to participate in IEHP's Vision Program.
IHA	Initial Health Assessment; Consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables the PCP to comprehensively assess the Member's current acute, chronic and preventive health needs.
IHEBA	Individual Health Education Behavioral Assessment; a tool used to assess Member's behavioral health awareness and educational needs as part of PCP's health assessment for Members.
IHSS	In-Home Supportive Services; a statewide mandated program that provides those with limited income who are disabled, blind or over the age of 65 with in-home care services.
IMD	Institute for of Mental Disease
IMR	Independent Medical Review; a process run by DMHC, which provides an avenue for Members to request that doctors and other healthcare professionals outside IEHP, make an independent decision about the Member's healthcare; when a Member has been denied healthcare services on the basis that the services are not medically necessary and IEHP has concurred with the decision after the Member has completed the IEHP's grievance process. DMHC is the final arbiter regarding coverage decisions review through the IMR process.
Incentive Pool	IEHP program designed to help appropriately control inpatient length of stays; funded for Mandatory Medi-Cal Members only.
IPA	Independent Physician Association; network of licensed Providers practicing in their own offices, participating in managed care plan; type of Providers under IEHP's program.
IRC	Inland Regional Center; agency responsible for providing intervention services through the Early Start Program for children at risk or identified as having developmental disabilities.
The Joint Commission	The Joint Commission formerly Joint Commission for the Accreditation of Healthcare Organization (JCAHO); a not-for-profit organization that accredits hospitals, outpatient facilities and other institutions.

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B. Glossary

TERM	*DEFINITION*
JOMs	Joint Operation Meetings; periodic meetings between IEHP and IPAs/Hospitals to address issues, delivery of care and general administration of plan.
JPA Governing Board	Joint Powers Agency Governing Board, also known as IEHP Governing Board; IEHP's oversight board consisting of appointed members from San Bernardino and Riverside Counties' Board of Supervisors and other appointed members that directs and approves all phases of IEHP operations.
LEA	Local Education Agency; school district agencies that provide certain services for Medi-Cal Members.
LHD	Local Health Department (Riverside/San Bernardino Counties); provides specific preventive and public health services, including immunizations, which Members can access directly.
LI Plan	Local Initiative Plan; Public/Private partnership plan of California's Two-Plan Model Managed Care Program designed to provide a publicly and privately funded managed care health plan to Medi-Cal recipients; in San Bernardino/Riverside Counties this plan is IEHP.
LOA	Leave of Absence
LOS	Length of Stay
Low Vision Aids	Lenses or optical devices used for those with significant vision loss. Low vision aids may include hand-held magnifiers or other high magnification devices. Members with significant vision loss may be eligible for a low vision aid benefit.
LTAC	Long Term Acute Care
LTC	Long Term Care; a term used for day-in, day-out assistance required for a serious illness or disability that lasts a long time and in which a person is unable to care for him/herself; it frequently refers to custodial or nursing home care.
LTSS	Long-Term Services and Supports; in state Medicaid programs are a means to provide medical and non-medical services to seniors and people with disabilities in need of sustained assistance.
Mainstream Plan	Commercial line of California's Two-Plan Model Managed Care Program designed to provide a prepaid managed care health plan to Medi-Cal recipients; in San Bernardino/Riverside Counties, this plan is Molina.
Managed Care	A coordinated approach to providing quality health care at a lower cost; usually associated with HMOs.
Mandatory Aid Codes	Group 1 – Family: 01, 02, 08, 0A, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7X, 82, 8P, 8R

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B. Glossary

TERM	*DEFINITION*
	Group 2 – Disabled (Medi-Cal only – Not Medicare Eligible): 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V Group 3 – Aged (Medi-Cal only – Not Medicare Eligible): 10, 14, 16, 1E, 1H
Marketing Materials	Materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to potential enrollees.
MBI	Medicare Beneficiary Identifier is a new randomly generated Medicare number that will replace the SSN-based Health Insurance Claim Number (HICN) on new Medicare cards for transactions like billing, eligibility status and claim status.
MBOC	Medical Board of California; the State agency that issues licenses to practitioners, including MDs and Pas.
MCO	Managed Care Organization; a term used in the industry, particularly by NCQA, for health plans that participate in managed care; also known as an HMO.
Medi-Cal	No-cost health care coverage for low-income adults, families with children, seniors, persons with disabilities, pregnant women, children in foster care and former foster youth up to age 26..
Medical Home	A place where a Member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care: a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support care management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards as set forth in W&I Code 14182I(13)(B).
Medically Necessary	Determined through professional peer review to be necessary and appropriate for vision care according to generally accepted standards of practice within the professional community. The fact that a Provider may prescribe, order recommendation or approve a service or material does not, in itself, deem it Medically Necessary or make the charge a Covered Service.
Medicare Advantage Prescription Drug Plan	Health Plan coverage that includes a specific set of health benefits offered at a uniform premium and uniform level of cost sharing to all Medicare beneficiaries residing in the service area (or segment of the service area) of the MA plan. An MA plan that provides qualified prescription drug coverage under Part D of the Social

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
HMO Special Needs Plan (SNP)	Security Act. Beneficiaries are eligible to join if they are entitled to Medicare Part A and enrolled in Medicare Part B and are enrolled in Medi-Cal.
Member(s)	Any recipient enrolled in IEHP's plan.
Member Handbook	The agreement between IEHP and the Member which describes Covered Services and which sets forth the terms and conditions of coverage and enrollment with IEHP.
MET	Member Evaluation Tool; The information collected from a health information form completed by beneficiaries at the time of enrollment by which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. Contractor shall receive the MET from the enrollment broker with the enrollment file and shall use the MET for early identification of Members' healthcare needs. For newly enrolled SPDs beneficiaries Contractor must use the MET as part of the health risk assessment process.
MDS	Minimum Data S–t - used as review or evaluation
MLTSS	Managed Long-Term Services and Supports
MRR	Medical Record Review; Assessment of medical records that is performed at the time of Facility Site Review or if medical records are available.
MSE	Medical Screening Exam; To determine whether a patient has an emergency medical condition.
MSO	Management Services Organization; provides practice management services to IPAs and/or Hospitals.
MSR	Member Services Representative; IEHP employee responsible for handling Member calls.
MSSP	Multipurpose Senior Services Waiver Program; a State program providing in-home care to Members as an alternative to institutionalization.
NCQA	National Committee for Quality Assurance; a private, not-for-profit organization that assesses and reports on the quality of managed care plans. NCQA provides information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed health care purchasing decisions.
NDC	National Drug Code
NF	Nurse Facility
NOA	Notice of Action

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B. Glossary

TERM	*DEFINITION*
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22 CCR Sections 51323, 51231.1, and 51231.2, rendered by licensed providers.
Non-Mandatory Aid Codes	Group 1 – Family: 03, 04, 06, 40, 42, 45, 46, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4T, 5K, 7J Group 2 – Disabled (Medi-Cal/Medicare eligible): 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V Group 3 – Aged (Medi-Cal/Medicare eligible): 10, 14, 16, 1E, 1H
Non-Physician Practitioner	Licensed Providers of Service that render limited medical services within their scope of license. Includes nurse practitioners (NP); physician assistants (PAs) and certified nurse midwives (CNMs).
Non-State Program	Any program where IEHP contracts with an employer group to render medical services for its employees.
NPDB	National Practitioner Data Bank; Department of Health and Human Services (DHHS) agency that collects and disseminates information on adverse licensure actions, clinical privilege actions and professional membership actions taken against physicians and dentists; used for credentialing purposes.
NQTL	Non-Quantitative Treatment Limits
Nurse Advice Line	A twenty-four (24) hour triage service provided to Members to help them with decisions regarding appropriate levels of medical care.
OIG	Office of Inspector General
OON	Out of Network
Organizational Provider	Any facility or entity providing inpatient, outpatient or home care services to Members; includes at a minimum, hospitals, ASCS, SNFs, HHAs, family planning clinics.
P&T Subcommittee	Pharmacy and Therapeutic Subcommittee; one of seven committees established by IEHP to oversee the quality of care provided to Members; P&T Subcommittee is a subcommittee of the QM Committee and is responsible for the overall formulary, related prescribing and usage patterns and activities.
PAC	Provider Advisory Council; one of seven committees developed by IEHP to oversee the quality of care provided to Members; the PAC addresses issues concerning the IEHP network.

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B. Glossary

TERM	*DEFINITION*
PARS	Physical Accessibility Review Survey; a facility site review assessment that is required of all PCPs, high volume specialists and designated high volume ancillary sites by the California Department of Health Care Services and Medi-Cal Managed Care Division.
PCP	Primary Care Physician; provides coordinated treatment of assigned Members; generally serves as the Member's "gatekeeper" for managed care plans. A physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W&I Code 14182 (b)(11). In rural areas, where PCP coverage is limited, Members may be assigned to a Nurse Practitioner at the discretion of IEHP.
Peer Review Subcommittee	Peer Review Subcommittee; one of seven committees established by IEHP to provide peer review and other quality related review of practitioners; Peer Review Subcommittee is a subcommittee of the QM Committee and addresses Member or Provider grievances, appeals and practitioner-related quality issues.
Per Diem	Payment to Hospitals contracting with IEHP under a "Per Diem Agreement"; a rate paid per day for services rendered regardless of actual charges.
Person-Centered Planning	A highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered planning is an integral part of Basic and Complex Case Management and Discharge Planning.
Persons with Disabilities Workgroup (PDW)	An IEHP workgroup, which consists of IEHP Members with disabilities and/or their designee(s), and representatives from community based organizations. This workgroup provides the health plan with recommendations on provisions of health care services, educational priorities, communication needs, and the coordination of and access to services for Members with disabilities.
PET	Performance Evaluation Tool; a tool used by IEHP during contract renewal to evaluate the overall performance and compliance of IPAs against IEHP requirements; outcome determines contract renewal period, type of contract, or non-renewal, if applicable.
PIA	Prison Industry Authority; a system of employment for inmates in California's prisons; used by the State and IEHP for making prescription lenses.
P4P	Pay For Performance formerly Physician Incentive Program (PIP); an incentive program introduced in 2000 that provides PCPs with additional compensation directly from IEHP for specific services rendered to Members.

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B. Glossary

TERM	*DEFINITION*
PMPM	Per Member Per Month; refers to a method of calculation reimbursement or expense, such as stop loss, based on each Member for one month.
PPC	Provider Preventable Conditions, which include both "Health Care Acquired Conditions (HCACs)" and "Other Provider Preventable Conditions (OPPCs), which are defined as conditions that: 1) are identified by the State Plan; 2) are reasonable preventable through the application of procedures supported by evidence-based guidelines; 3) have negative consequence for the beneficiary, 4) are auditable; and 5) include, at minimum, wrong surgical or other invasive procedure performed on a patient, performed on the wrong body part, or performed on the wrong patient.
PPPC	Public Policy Participation Committee; one of seven committees developed by IEHP to oversee the quality of care provided to Members; PPPC is a Member based Committee responsible for addressing IEHP structural or operational issues that can potentially impact delivery of care.
PQI	Potential Quality Incident
Practitioner	Any medical Physician practicing medicine (i.e. PCPs/Specialists) or non-physician practicing medicine (i.e. Physician Extenders, Nurse Practitioners, Certified Nurse Midwives, Occupational Therapist, Speech Therapist, or Physical Therapist.
Practitioner Profile	A form required by IEHP for submitting credentialed practitioners to IEHP for inclusion in the IEHP network; includes key practitioner demographic information and qualifications.
Prescription Drug Prior Authorization or Step Therapy Exception Request Form (RxPA)	Submission of this specific universal form to request for prior authorization of all non-formulary drugs is required for the Medi-Cal lines of business.
Preventive Care	Means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67 (f) of Title 28.
Provider	Any Health Care Provider (i.e. PCP, Specialists, OB/GYN, Behavioral Health, Vision, or Ancillary Providers).

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Provider Team	Provider Team; triage unit established by IEHP to resolve Provider and Member issues concerning delivery of care to Members and to address Provider's questions.
PSR	Provider Services Representative; IEHP employee responsible for educating, assisting and resolving Provider issues.
QM	Quality Management; the continuous monitoring of all aspects of health care being administered to IEHP Members.
QM Committee	Quality Management Committee; one of seven committees developed by IEHP to oversee the quality of care provided to Members; the QM Committee monitors and addresses all aspects of health care provided to Members.
QPN	Quality Program Nurse; IEHP employee responsible for monitoring quality management at PCP offices, IPAs and Hospitals.
QTL	Quantity Treatment Limitations
RA	Remittance Advice: A statement that describes the service payments and adjustments that is included in IEHP Provider reimbursements.
Residency Clinic	Clinics that operate full-time (Monday to Friday, approximately 8:00am to 5:00pm) as sites for the training of residents in a primary care discipline from an accredited residency training program.
Semi-Annually	Twice yearly; used interchangeably with bi-annual.
Service Authorization Request	A Member's request for the provision of a Covered Service.
SNF	Skilled Nursing Facility; a facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of lesser intensity than that received in a hospital.
Specialty Care Center	A center that is accredited or designated by the State or federal government, or by a voluntary national health organization, as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
SPD	Seniors and Persons with Disabilities; Medi-Cal beneficiaries who fall under specific Aged and Disabled aid codes as defined by the department (See Eligible Beneficiary).
SRAE	Serious Reportable Adverse Events

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Standing Referral	A referral by a Primary Care Physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.
State Program	Any program administered and/or funded by any federal, state or local county agency that does not involve an employer group; specifically, Medi-Cal or Open Access Program Members.
Stop-Loss	Insurance coverage provided by a third party that pays in event of unexpected financial loss.
Terminally Ill	This means that an individual has a medical prognosis that his or her life expectancy is six (6) months or less if the illness runs its normal course.
TTY	Teletypewriter Device for the Hearing Impaired; formally known as Telephone Teletypewriter (TTY); an interpretive tool used to allow hearing impaired Members to access services or care by telephone.
TPA	Third Party Administrator; an administrative organization other than the health plan; Provider or Provider of Service that collects premiums, pays claims and/or provides administrative services.
TPL	Third Party Liability; another party that has the obligation to cover all or any portion of the medical expense incurred by a Member at the time such services was delivered; usually involving tort liability of another insurance-based entity such as workers' compensation or automobile insurance.
Triage or Screening	Means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.
Triage or Screening Waiting Time	Means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care.
Two-Plan Model Managed Care Program	Developed by DHCS to transfer delivery of Medi-Cal medical care to capitated managed care programs; thirteen counties participate in the program, which consists of a commercial (mainstream) plan and a county public/private partnership (local initiative) plan.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
UCR	Usual, Customary and Reasonable Fee; The "usual" charge is the fee usually charged for a given service or material, by a Provider, to their private patients. A charge is "customary" when it is within the range of the usual fees charged by the Providers of similar training and experience, for the same service or material as determined by IEHP through its professional review process. The charge is "reasonable" when it meets the above two criteria or is justifiable as determined by IEHP through its professional review process in consideration of special circumstances of a particular case.
UM	Utilization Management; delegated to IPA; performs oversight of authorization processes and review of Member usage of services for continuous quality improvement.
UM Subcommittee	Utilization Management Subcommittee; One of seven committees established by IEHP to oversee the quality of care provided to Member; it is a subcommittee of the QM Committee and continuously monitors all aspects of UM administered to IEHP Members, including medical criteria used in the evaluation of appropriate health care services provided to Members.
Urgent Care	Means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of Section 1367.01 of the Act.
USPSTF	United States Preventive Services Task Force
Utilization	The frequency with which a service is used.
VER	Vision Exception Request; used to request an exception to the standard benefit and to request authorization for non-covered or non-routine medically necessary vision services or lenses.
VFC	Vaccines for Children Program; a federally funded state program providing PCPs with free vaccines for administration to eligible children.
Waste	Waste includes overuse of services, or other practices that, directly or indirectly, results in unnecessary cost. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources (i.e., extravagant careless or needless expenditure of healthcare benefits/services).
WIC	Supplemental Food Program for Women, Infants and Children; a state program for eligible Members which provides nutrition assessments, education, counseling, coupons for food supplements and links to community resources.

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