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## 24. QUICK REFERENCE

### A. Quick Reference Guide

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#### IEHP Quick Reference Guide

##### IEHP:

Main Number: (909) 890-2000  
Main Fax Number: (909) 890-2002  
Provider Services Support Team: (909) 890-2054  
Provider Relations Fax: (909) 890-5652

##### Eligibility:

IVR Number: (888) 440-4340  
(24 hrs./ 7 days)  
Local IVR Number: (909) 890-3800  
(24 hrs./ 7 days)  
Provider Eligibility Line: (866) 222-IEHP (4347)

##### 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 Web Site: [www.iehp.org](http://www.iehp.org)

*Closed For:*

<i>New Years Day</i>	<i>Thanksgiving Day</i>
<i>Martin Luther King, Jr. Day</i>	<i>Day After Thanksgiving</i>
<i>Presidents' Day</i>	<i>Christmas Eve</i>
<i>Memorial Day</i>	<i>Christmas Day</i>
<i>Independence Day</i>	<i>*New Years' Eve</i>
<i>Labor Day</i>	

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

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### B. Glossary

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<i>TERM</i>	<i>DEFINITION</i>
<b>AAO</b>	American Academy of Ophthalmology.
<b>AAP</b>	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.
<b>ABMS</b>	American Board of Medical Specialties; delineates board certification standards; used for credentialing purposes.
<b>ABPS</b>	American Board of Podiatric Specialties; issues board certification to qualifying practitioners; used for credentialing purposes.
<b>ACIP</b>	Advisory Committee on Immunization Practice; national entity that issues guidelines on immunizations; DHCS contract mandates that these guidelines be followed by IEHP network PCPs.
<b>ADDAG</b>	Americans with Disabilities Act Access Guidelines
<b>ADHC</b>	Adult Day Health Care Center; a DHCS licensed community based day care program providing a variety of health, therapeutic and social services to those at risk of being placed in a nursing home.
<b>Advance Directive</b>	A written legal document that allows a person or someone designated to speak on another's behalf to make health care decisions when that person is unable to do so; sometimes known as a "living will" or "durable power of attorney for healthcare."
<b>AEVS</b>	Automated Eligibility and Verification System; DHCS phone system to verify eligibility for Medi-Cal recipients.
<b>Agreement</b>	Same as contract; signed document between IEHP and Providers outlining responsibilities of both parties, may be capitated or per diem.
<b>AOA</b>	American Osteopathic Association; an organization that licenses osteopathic physicians; it also accredits hospitals; used for credentialing and oversight purposes.
<b>Appointment Waiting Time</b>	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.
<b>ASC</b>	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.

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<i>TERM</i>	<i>DEFINITION</i>
<b>Basic Case Management</b>	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.
<b>Bed Day</b>	Same as Hospital Day; any period up to 24 hours, commencing at 12:00AM during which a Member receives inpatient hospital services.
<b>Behavioral Health</b>	Includes all mental health (psychiatric, psychological and behavioral disorders) and substance abuse disorders.
<b>Benefit Year</b>	The benefit year for Healthy Families and Healthy Kids Members is July 1 <sup>st</sup> through June 30 <sup>th</sup> , annually.
<b>Bi-annual</b>	As used by IEHP; means twice yearly; synonymous with semi-annual.
<b>BIC Card</b>	Benefit Identification Card; issued to Medi-Cal recipients by DHCS; used to identify beneficiaries as Medi-Cal Members; does not guarantee eligibility.
<b>CAP</b>	Corrective Action Plan; written plan by a Provider to remedy deficiencies.
<b>Capitation</b>	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.
<b>Care Coordination</b>	Services which are included in Basic 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.
<b>CBO</b>	Community Based Organization; an entity providing resources and information on various programs, e.g., Catholic Services.
<b>CCS</b>	California Children Services; State program that is locally administered which provides diagnostic services, medical treatment and case management services for eligible children.
<b>CDC</b>	Centers for Disease Control Prevention
<b>CDS</b>	Controlled Dangerous Substance; similar to DEA certification; an authorization issued to physicians writing prescriptions for controlled substances; used for credentialing purposes.
<b>CHDP Program</b>	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.

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<b>TERM</b>	<b>DEFINITION</b>
<b>CIN</b>	Client Index Number; a nine digit alphanumeric number assigned to Medi-Cal Members by DHCS, Healthy Families by MRMIB and Healthy Kids by IEHP for Member identification.
<b>CM</b>	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.
<b>CMS</b>	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.
<b>CMS-1500 Claim Form</b>	A federally approved claim form that meets the Centers for Medicare and Medicaid Services health insurance information collection requirements
<b>Clean Claim</b>	A claim that can be processed without obtaining additional information from the provider of services or from a third party.
<b>COB</b>	Coordination of Benefits; a process followed when a Member has duplicate coverage where by the total cost of care for the Member either paid or reimbursed does not exceed 100%.
<b>Cold-Call Marketing</b>	Any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing (as identified within the definition of Marketing).
<b>Complex Case Management</b>	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. Complex Case Management includes Basic Case Management.
<b>Comprehensive Medical Case Management Services</b>	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.
<b>Covered Services</b>	Vision care services and materials that are described as benefits in the Member's Handbook and EOC.
<b>CPSP</b>	Comprehensive Perinatal Services Program; a Medi-Cal program that provides a model of enhanced obstetric services for eligible low-income, pregnant and postpartum women.

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<i>TERM</i>	<i>DEFINITION</i>
<b>CPT</b>	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.
<b>Credentialing</b>	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.
<b>Credentialing Subcommittee</b>	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.
<b>CVO</b>	Credentialing Verification Organization; an entity that performs pre-determined credentialing processes, such as primary source verifications.
<b>Days</b>	Unless otherwise stated, days always means calendar days; usually shown in lower case.
<b>DDS</b>	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.
<b>DEA</b>	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.
<b>DHCS</b>	Department of Health Care Services formerly DHS; State agency responsible for oversight of the Two-Plan Model Managed Care Program and IEHP's operations.
<b>Discharge Planning</b>	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.
<b>Dispensing Fee</b>	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.
<b>DMHC</b>	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.

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<i>TERM</i>	<i>DEFINITION</i>
<b>DPA</b>	Diagnostic Pharmaceutical Agent; a state certificate that grants the privilege to Optometrists to use certain medications for diagnostic purposes.
<b>DPSS</b>	Department of Public Social Services; State agency responsible for the administration of health and welfare benefits, including eligibility for Medi-Cal.
<b>ED</b>	Emergency Department.
<b>EDS</b>	Electronic Data Systems; entity used by MRMIB to handle enrollment of Healthy Families Members and to transmit Healthy Families and Medi-Cal eligibility data to IEHP.
<b>EFT</b>	Electronic Funds Transfer; the mechanism by which capitation payments are made electronically to Providers by IEHP.
<b>Encounter</b>	Each visit a Member makes to a practitioner or Provider.
<b>Encounter Data</b>	Mandatory encounter data reported to IEHP by its Providers; includes detailed information on services provided to each Member in each month.
<b>EOC</b>	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.
<b>EPSDT</b>	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.
<b>Explanation Codes</b>	Codes used on the Remittance Advice (RA) to reflect claim adjustments made by IEHP.
<b>FAME</b>	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.
<b>FFS</b>	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.
<b>Formulary</b>	A list of medications approved by the Plan.
<b>FPC</b>	Fraud Prevention Committee; IEHP's administrative committee that oversees all activities of its FPP.
<b>FPP</b>	Fraud Prevention Program; Developed to train IEHP staff and Providers to identify, deter, prevent and report suspected fraudulent activities.

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<i>TERM</i>	<i>DEFINITION</i>
<b>FTP</b>	File Transfer Protocol; method used to obtain and transmit Member eligibility and encounter data from/to IEHP.
<b>HCBS</b>	Home and Community Based Services Waiver Program; DDS program providing in-home care to Members with developmental disabilities.
<b>HCFA</b>	(see CMS);
<b>HCFA - 1500 Claim</b>	(see CMS-1500 Claim Form).
<b>HF</b>	Healthy Families Program; Low-cost health, dental, and vision coverage to uninsured children in working families, until the age of 19.
<b>HK</b>	Healthy Kids Program; Low-cost health, dental, and vision coverage to low-income uninsured children until the age of 19, who do not qualify for no-cost Medi-Cal or the Healthy Families Program.
<b>HEBA</b>	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.
<b>HEDIS</b>	Health Plan Employer Data and Information Set; a core set of performance measures to assist employers and other health purchasers in understanding the value of health care purchases and evaluating health plan performance.
<b>HCO</b>	Health Care Options, a unit of DHCS; handles both enrollment and disenrollment of Medi-Cal recipients; sometimes used interchangeably with Maximus.
<b>HHA</b>	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.
<b>HMO</b>	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.
<b>Hospital Day</b>	Same as bed day.
<b>ICD-9-CM</b>	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's International Classification of Diseases, Ninth Revision (ICD-9). ICD-9-CM is used to code morbidity data and starting with the data year 1999 ICD-10 is used to code and classify mortality data. The ICD-9-CM is arranged in 17 main chapters. Most of the diseases are arranged according to their principal anatomical site, with special chapters for infective and parasitic diseases; neoplasms; endocrine, metabolic, and nutritional diseases; mental diseases; complications of pregnancy and childbirth; certain diseases peculiar to the perinatal period; and ill-defined conditions.

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<b>TERM</b>	<b>DEFINITION</b>
<b>ICD-10-CM</b>	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Clinical Modification. ICD-10-CM is planned as the replacement for ICD-9-CM, volumes 1 and 2. However, the codes in ICD-10-CM are not currently valid for any purpose or uses. There is not yet an anticipated implementation date for the ICD-10-CM. Implementation will be based on the process for adoption of standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There will be a two year implementation window once the final notice to implement has been published in the Federal Register.
<b>ICP</b>	Individualized Care Plan; treatment and intervention program for pregnant Members developed by OB; required by IEHP.
<b>IEHP Identification Card</b>	Issued by IEHP to Members; identifies PCP and Hospital affiliations; used for identifying beneficiaries as IEHP Members; does not guarantee eligibility.
<b>IEHP Medicare DualChoice (HMO SNP)</b>	IEHP's health care coverage for beneficiaries who have full-scope, zero share of cost Medicare, and full-scope Medi-Cal. IEHP Medicare DualChoice (HMO SNP) connects Medicare, Medi-Cal and pharmacy benefits into one simple plan.
<b>IEHP Vision Provider</b>	An Optometrist, Ophthalmologist or Optician who has signed a contract to participate in IEHP's Vision Program.
<b>IHA</b>	Initial Health Assessment; a targeted exam, which assesses medical history and current medical condition of newly enrolled Members.
<b>IMR</b>	Independent Medical Review; a process ran 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.
<b>Incentive Pool</b>	IEHP program designed to help appropriately control inpatient length of stays; funded for Mandatory Medi-Cal Members only.
<b>IPA</b>	Independent Physician Association; network of licensed Providers practicing in their own offices, participating in managed care plan; type of Providers under IEHP's program.
<b>IRC</b>	Inland Regional Center; agency responsible for providing intervention services through the Early Start Program for children at risk or identified as having developmental disabilities.

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<i>TERM</i>	<i>DEFINITION</i>
<b>IVR</b>	Interactive Voice Response; IEHP's telephone-accessible Member eligibility verification system.
<b>The Joint Commission</b>	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.
<b>JOMs</b>	Joint Operation Meetings; periodic meetings between IEHP and IPAs/Hospitals to address issues, delivery of care and general administration of plan.
<b>JPA Governing Board</b>	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.
<b>LEA</b>	Local Education Agency; school district agencies that provide certain services for Medi-Cal Members.
<b>LHD</b>	Local Health Department (Riverside/San Bernardino Counties); provides specific preventive and public health services, including immunizations, which Members can access directly.
<b>LI Plan</b>	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.
<b>Low Vision Aids</b>	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.
<b>LTC</b>	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.
<b>Mainstream Plan</b>	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.
<b>Managed Care</b>	A coordinated approach to providing quality health care at a lower cost; usually associated with HMOs.
<b>Mandatory Aid Codes</b>	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 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

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<i>TERM</i>	<i>DEFINITION</i>
<b>Marketing Materials</b>	Materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to potential enrollees.
<b>MBHO</b>	Managed Behavioral Healthcare Organization; A health plan, insurance company, self-funded plan, or Health Maintenance Organization (HMO) that offers managed care products for behavioral health while setting up and administering behavioral health provider networks.
<b>MBOC</b>	Medical Board of California; the State agency that issues licenses to practitioners, including MDs and PAs.
<b>MCO</b>	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.
<b>Medi-Cal</b>	No-cost health care coverage for low-income working families with children, low-income seniors, and people with disabilities.
<b>Medical Home</b>	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 14182(c)(13)(B).
<b>Medically Necessary</b>	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.
<b>Medicare Advantage Prescription Drug Plan HMO Special Needs Plan (SNP)</b>	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 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.

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<i>TERM</i>	<i>DEFINITION</i>
<b>Member(s)</b>	Any recipient enrolled in IEHP's plan.
<b>Member Handbook</b>	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.
<b>MET</b>	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.
<b>MRMIB</b>	Managed Risk Medical Insurance Board; State agency responsible for administration of the Healthy Families Program.
<b>MSO</b>	Management Services Organization; provides practice management services to IPAs and/or Hospitals.
<b>MSR</b>	Member Services Representative; IEHP employee responsible for handling Member calls.
<b>MSSP</b>	Multipurpose Senior Services Waiver Program; a State program providing in-home care to Members as an alternative to institutionalization.
<b>NCQA</b>	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.
<b>Non-Emergency Medical Transportation</b>	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.
<b>Non-Mandatory Aid Codes</b>	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

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<i>TERM</i>	<i>DEFINITION</i>
<b>Non-Physician Practitioner</b>	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).
<b>Non-State Program</b>	Any program where IEHP contracts with an employer group to render medical services for its employees.
<b>NPDB</b>	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.
<b>Nurse Advice Line</b>	An after hours triage service provided to Members to help them with decisions regarding appropriate levels of medical care.
<b>Organizational Provider</b>	Any facility or entity providing inpatient, outpatient or home care services to Members; includes at a minimum, hospitals, ASCS, SNFs, HHAs, family planning clinics.
<b>P3</b>	Pre-Existing Pregnancy Program; formally known as Third Trimester Pregnancy Program (TTPP); an IEHP Program that compensates Providers for the financial impact of providing services to a pregnant Member assigned to a Provider late in the pregnancy.
<b>P&amp;T Subcommittee</b>	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.
<b>PAC</b>	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.
<b>PCP</b>	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.

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<b>TERM</b>	<b>DEFINITION</b>
<b>Peer Review Subcommittee</b>	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.
<b>PER</b>	Pharmacy Exception Request forms; used to request authorization for use of non-formulary drugs.
<b>Per Diem</b>	Payment to Hospitals contracting with IEHP under a “Per Diem Agreement”; a rate paid per day for services rendered regardless of actual charges.
<b>Person-Centered Planning</b>	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.
<b>PET</b>	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.
<b>PIA</b>	Prison Industry Authority; a system of employment for inmates in California’s prisons; used by the State and IEHP for making prescription lenses.
<b>P4P</b>	Pay For Performance formerly Physician Incentive Program (PIP); new incentive program introduced in 2000 that provides PCPs with additional compensation directly from IEHP for specific services rendered to Members. Replaces former Immunization Program.
<b>PMPM</b>	Per Member Per Month; refers to a method of calculation reimbursement or expense, such as stop loss, based on each Member for one month.
<b>PPPC</b>	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.
<b>Practitioner</b>	A physician, non-physician medical practitioner, or other provider of service.
<b>Practitioner Profile</b>	A form required by IEHP for submitting credentialed practitioners to IEHP for inclusion in the IEHP network; includes key practitioner demographic information and qualifications.
<b>Preventive Care</b>	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.

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<i>TERM</i>	<i>DEFINITION</i>
<b>Provider</b>	With an uppercase “P”; entity directly contracted with IEHP, i.e., IPA or Hospital; with a lowercase “p”; provider of service or entity providing services to IEHP Members.
<b>Provider Team</b>	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.
<b>PSR</b>	Provider Services Representative; IEHP employee responsible for resolving Provider issues.
<b>QM</b>	Quality Management; the continuous monitoring of all aspects of health care being administered to IEHP Members.
<b>QM Committee</b>	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.
<b>QPN</b>	Quality Program Nurse; IEHP employee responsible for monitoring quality management at PCP offices, IPAs and Hospitals.
<b>RA</b>	Remittance Advice: A statement that describes the service payments and adjustments that is included in IEHP Provider reimbursements.
<b>Semi-Annually</b>	Twice yearly; used interchangeably with bi-annual.
<b>Service Authorization Request</b>	A Member’s request for the provision of a Covered Service.
<b>SNF</b>	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.
<b>Specialty Care Center</b>	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.
<b>SPD</b>	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).

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## 24. QUICK REFERENCE

### B. Glossary

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<i>TERM</i>	<i>DEFINITION</i>
<b>Standing Referral</b>	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.
<b>State Program</b>	Any program administered and/or funded by any federal, state or local county agency that does not involve an employer group; specifically, Medi-Cal, Healthy Families, Healthy Kids or Open Access Program Members.
<b>Stop-Loss</b>	Insurance coverage provided by a third party that pays in event of unexpected financial loss.
<b>TTY</b>	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.
<b>TPA</b>	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.
<b>TPL</b>	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.
<b>Triage or Screening</b>	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.
<b>Triage or Screening Waiting Time</b>	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.
<b>Two-Plan Model Managed Care Program</b>	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.

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## 24. QUICK REFERENCE

### B. Glossary

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<i>TERM</i>	<i>DEFINITION</i>
<b>UCR</b>	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.
<b>UM</b>	Utilization Management; delegated to IPA; performs oversight of authorization processes and review of Member usage of services for continuous quality improvement.
<b>UM Subcommittee</b>	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.
<b>Urgent Care</b>	Means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of Section 1367.01 of the Act.
<b>Utilization</b>	The frequency with which a service is used.
<b>VER</b>	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.
<b>VFC</b>	Vaccines for Children Program; a federally funded state program providing PCPs with free vaccines for administration to eligible children.
<b>VSC</b>	Vision Services Coordinator; responsible for routine and non-routine authorizations through the means of a VER.
<b>WIC</b>	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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